

The Massachusetts Prevention and Wellness Trust Fund 2014 Legislative Report

BUREAU OF COMMUNITY HEALTH AND PREVENTION

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH



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Charles D. Baker, Governor
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The Massachusetts Department of Public Health prepared this report in accordance with paragraphs G and H of Section 60 of Chapter 224 of the Acts of 2012.

Chapter 224 of the Acts of 2012, Section 60, Paragraphs G and H

The department of public health shall, annually on or before January 31, report on expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable to the administrative costs of the department of public health; (3) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; (4) the results of the evaluation of the effectiveness of the activities funded through grants; and (5) an itemized list of expenditures used to support workplace-based wellness or health management programs. The report shall be provided to the chairpersons of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.

The department of public health shall, under the advice and guidance of the Prevention and Wellness Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy, including, but not limited to: (1) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socio-economic status; (2) a list of the most costly preventable health conditions in the commonwealth; (3) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (1) and (2); and (4) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (1) and (2). The report shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention and Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.

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And special thanks to the Prevention and Wellness Advisory Board for their guidance and comments in developing this report.

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I. EXECUTIVE SUMMARY

This is the second annual legislative report on the activities of the Prevention and Wellness Trust Fund (PWTF)¹. This report summarizes the significant progress made by the Massachusetts Department of Public Health (DPH; the Department) and partner organizations toward designing and implementing programs to achieve the goals outlined for the PWTF in Chapter 224 of the Acts of 2012 (Chapter 224). As stated in the legislation, the PWTF will be used to achieve reductions in the prevalence of preventable health conditions and reductions in health care costs or the growth in health care cost trends. In addition, the PWTF will be used to assess which groups benefitted from any reductions and whether worksite wellness initiatives played a role in these improvements.

The PWTF is funded through a one-time assessment on acute hospitals and payers totaling \$57 million. Under the law, PWTF funds must be allocated as follows: no less than 75% (\$42,500,000) must be expended for a grantee program; up to 10% (\$5,700,000) can be used for worksite wellness initiatives; and, no more than 15% (\$8,550,000) can be spent by DPH on the administration and evaluation of these initiatives.

2014 was a very active year for the PWTF. Working with the Prevention and Wellness Advisory Board (PWAB), as well as internal and external subject matter experts, the Department made critical design decisions for the Grantee Program including: a strong focus on extending care beyond clinical sites into the community; utilizing a data-driven quality improvement approach; establishing funding levels and population size for each grantee; promoting future sustainability; and, selecting priority and optional health conditions based on the existence of evidence-based interventions and the likelihood of impacting health and reducing healthcare costs within the lifespan of the Trust. The priority conditions, at least two of which must be addressed by each grantee, are hypertension, falls among older adults, pediatric asthma and tobacco use. The optional conditions include substance abuse, obesity, oral health, and diabetes.

Nine grantee partnerships were selected through a highly competitive procurement process and represent communities with high need as defined by health condition prevalence, poverty level, health outcomes, and racial health disparities. Each partnership is required to include clinical sites, community-based organizations, and municipalities. In addition, a number of partnerships have added other types of organizations such as regional planning agencies, insurers, and legal assistance providers. By supporting these partnerships, DPH will help communities build relationships and linkages between these organizations to better serve their clients/patients where they live, work and play, as well as where they seek medical care.

The grantee partnerships that were selected for funding are:

Barnstable Partnership – Coordinating Partner: Barnstable County Department of Human Services

Berkshire County Partnership – Coordinating Partner: Berkshire Medical Center

Boston Partnership – Coordinating Partner: Boston Public Health Commission

Healthy Holyoke Partnership – Coordinating Partner: Holyoke Community Health Center

Lynn Partnership – Coordinating Partner: City of Lynn

MetroWest Partnership - Coordinating Partner: Town of Hudson

Quincy Weymouth Partnership- Coordinating Partner: Manet Community Health Center

SHIFT Partnership – Coordinating Partner: City of New Bedford Health Department

Worcester Partnership – Coordinating Partner: City of Worcester

In order to promote coordination between clinical and community sites, which is the cornerstone of the PWTF model, the Department has required the use of electronic referral (e-Referral) by all grantees. This novel system was developed by DPH through the Commonwealth's State Innovation Model (SIM) grant

¹ For the first year's legislative report, please see: <http://www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/annual-report-2013.pdf>

award from the Centers for Medicare and Medicaid Services (CMS). An e-Referral is initiated by a clinical provider and sent through their electronic medical record (EMR), or electronic health record (EHR), to a community-based organization that offers an appropriate intervention for a given patient. The community-based organization then contacts the patient/client to explore interest and enrolls the patient in the community intervention. After engagement in the intervention, the community-based organization sends a feedback report containing agreed upon patient information back to the originating clinical organization via the e-Referral system. This electronic referral and communication system not only documents referrals and improves communications between the two (or more) organizations on behalf of a patient, but also serves as a way to document and evaluate the health outcomes of community-based, health related interventions in an efficient new way. This is an important tool for community-based organizations to demonstrate their effectiveness in reaching and positively impacting their patients.

Evaluating the Grantee Program is required by statute and determining the impact of the implemented interventions will rely on three key factors:

- linkages across data sets
- utilization rates of evidence-based interventions that are high enough to yield measureable effects when populations are compared, and
- sufficient time for changes in behavior to result in clinical improvements and cost reductions

The specific analytic models have yet to be determined. However, procurement for an outside evaluator is in process.

The Department also made significant progress in developing the required worksite wellness initiative in 2014. PWTF funds will allow DPH to expand the scope of the previous Working on Wellness program, and provide seed funding to a much larger group of businesses to support wellness programs. The goal is to reach 450 worksites that will participate in a year-long training program as part of three cohorts with staggered start dates. Participating businesses will receive training and technical assistance (TA) on comprehensive workplace wellness program development in the form of webinars, group TA calls, and participation in an online learning community which will include resource sharing, self-guided learning modules with case studies and success stories, and access to TA. Training and TA will be provided to ensure eligible businesses meet all criteria for the Massachusetts Wellness Tax Credit (note: seed funding will not be an eligible expense for the credit). The amount of seed funding will depend upon the number of employees in the business, with a cap to be determined by DPH in collaboration with the selected vendor, and will be contingent upon certain participatory and outcome benchmarks (e.g., must attend a certain number of webinars and group TA calls, complete a health risk assessment with a minimum percentage of employee participation, etc.). A procurement to support this initiative was released in early January 2015 and a contract will begin spring 2015.

The four-year PWTF budget allocates \$8,550,000 (15%) for administrative and evaluation expenses including staff and contractors to support evaluation, technical assistance, IT, and other support for funded partnerships. \$42,750,000 (75%) has been budgeted to fund community grantees and \$5,700,000 (10%) for worksite wellness activities.

II. BACKGROUND

Chapter 224 of the Acts of 2012 (Chapter 224) is the second legislative phase of comprehensive health reform and focuses on improving the quality of care and reducing health care costs. Section 276 of Chapter 224 establishes the Prevention and Wellness Trust Fund (PWTF) and provides five explicit goals for its implementation:

1. A reduction in the prevalence of preventable health conditions;
2. A reduction in health care costs or the growth in health care cost trends;
3. An assessment of which groups benefitted from any reduction;
4. An assessment of whether workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; and
5. If employee health and productivity was improved or employee recidivism was reduced, an estimate of the statewide financial benefit to employers.

The PWTF goals are ambitious. Given rising health care costs, any initiative that achieves a measurable decrease in the prevalence of preventable health conditions and the health care costs associated with these conditions in less than four years will be a model for other states embarking on this path. The Massachusetts Department of Public Health (DPH) has embraced these goals and, utilizing statutory requirements and the guidance of the Prevention and Wellness Advisory Board (PWAB), has developed and is implementing a plan that maximizes the chances of achieving them.

The PWTF is funded through a one-time, \$57 million assessment on acute hospitals and payers. Under the law, PWTF funds must be allocated as follows: no less than 75% (\$42,500,000) must be expended for a grantee program; up to 10% (\$5,700,000) can be used for worksite wellness initiatives; and no more than 15% (\$8,550,000) can be spent by DPH on the administration and evaluation of these initiatives. This report summarizes the activities that have taken place in calendar year 2014 to implement the PWTF.

As in its first year of implementation (2013), PWTF activities undertaken in 2014 were directed towards assuring sustainable change within health care settings, community settings and worksites. The PWTF Grantee Program, in particular, was developed using a framework designed to break down silos and imbed new protocols and referral relationships as part of standard operating procedures. Key design decisions to support long term sustainability are reviewed as part of the “Framework” section below.

III. THE PREVENTION AND WELLNESS TRUST FUND GRANTEE PROGRAM

A. Framework

In August 2013, DPH released a Request for Responses (RFR) to select the grantees to be funded under the PWTF. This procurement reflected a number of key design decisions made by the Department, with the guidance and consent of the Prevention and Wellness Advisory Board (see Section VIII below), to foster achievement of the Trust's ambitious goals as well as sustainability beyond the existing PWTF funding.

Extending Care into the Community:

As most people with chronic conditions spend the majority of their time living, working, and going to school in the community, prevention and intervention activities should be extended into community settings. This work also should be linked to clinical practices, which can serve as access points for primary, secondary and tertiary prevention services. The U.S. Surgeon General's National Prevention Strategy, the Agency for Healthcare Research and Quality's National Quality Strategy, and the Expanded Care Model promote the linkage of clinical practice with community resources to help prevent and control chronic diseases. In recent years, public health has increased its efforts to link more effectively with health systems by using community resources and supportive environments to complement and strengthen delivery of clinical care. By linking advocacy efforts to support a broad range of activities (such as smoke-free housing and tobacco cessation programming) in low income areas with health interventions, there is evidence to suggest both cost savings and improved health outcomes can be achieved.²

Therefore, the Department required grantees to include three types of organizations in their partnership:

- Clinical (healthcare providers, clinics, hospitals) – at least one clinical partner must use and be able to share electronic medical records
- Community (schools, fitness centers, non-profits, and multi-service organizations)
- Other (municipalities, regional planning agencies, worksites, and insurers)

These partnering organizations are expected to work together to improve clinical care, develop individual behavior change programs within the community, and link patients between clinical and community settings to control and prevent the selected priority conditions. Further, partnerships are encouraged to create policy and environmental changes in both settings in order to build sustainable change.

Sustainable Change

The goal of the PWTF is to fund the development and implementation of effective, sustainable interventions and systems to improve health and reduce costs. DPH staff focused on the issue of sustainability both in terms of assuring continuation of the specific interventions beyond the life of PWTF funding and in terms of maintaining established relationships, policies and protocols. By emphasizing the breakdown of barriers (particularly between clinical and community settings), opportunities to produce sustainable change emerge. For example, the program design emphasizes features such as lasting changes to electronic medical records (EMR) that embed clinical decision supports and electronic referral capacity into a clinical practice tool that will outlive the PWTF grant period. Community level policy changes promoted by PWTF partnerships will also be sustained beyond the grant period. Additionally, as evaluation results demonstrate improved health and reduced healthcare spending, DPH hopes that there will be interest on the part of payers in supporting effective interventions through future payment structures.

²Woulfe J, Oliver TR, Zahner SJ, Siemering KQ. Multisector partnerships in population health improvement. *Prev Chronic Dis* 2010;7(6):A119. http://www.cdc.gov/pcd/issues/2010/nov/10_0104.htm. Accessed on 12/31/2013.

Priority Conditions:

Working with the PWAB, DPH reviewed information on thirteen prevalent and costly health conditions in Massachusetts³. To determine priority conditions, consideration was given to prevalence of the condition in the population, associated health care costs for the condition, whether there was a known evidence base for intervention, whether the intervention was likely to yield return on investment within three to five years, and whether data would be available to evaluate the impact of the intervention. As a result of this analysis, four priority conditions were selected: Pediatric Asthma, Hypertension, Tobacco Use and Falls in Older Adults. Four optional conditions, for which the evidence base and therefore the potential for reducing health care costs within the four years of the PWTF was less strong, were also identified. These conditions were Diabetes, Oral Health, Obesity, and Substance Abuse. In order to increase the likelihood of success in achieving return on investment as well as promoting the establishment of new relationships in these communities, each partnership was required to address at least two of the four priority conditions. Mental health conditions were identified to be considered as co-morbid conditions.

Population Size and Funding Levels:

To determine the appropriate population size and service area for the available resources, DPH evaluation staff examined large multi-sector, multi-factor interventions programs like the Community Transformation Grants and the Childhood Obesity Demonstration Grant as well as return on investment studies of worksite wellness programs.⁴ It was clear from this examination that investing too little in a community was just as problematic as investing too much if PWTF was to achieve a positive return on investment. While there is no universally accepted methodology for determining the optimal population size and optimal per capita funding level, DPH staff considered three significant factors:

1. The total reduction in healthcare costs necessary to recoup the \$57 million investment across different population sizes,
2. The intensity/costliness of interventions, and
3. The effectiveness of interventions.⁵

Based on this analysis, DPH proposed a cap of no fewer than six awards and no more than twelve. Each award would focus on a population between 30,000 and 120,000 people. Annual award amounts would be \$250,000 for the capacity-building phase and range from \$1.1 million to \$2.5 million per year for the remaining three years when programs were fully implementing the interventions.

Data Driven Quality Improvement:

In addition to driving grantees toward implementing evidence-based interventions, the PWTF Grantee Program is built upon the use of data to drive change and to measure results. Primary data sources for quality improvement will include an electronic referral system (e-Referral) developed through a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model Testing Award, the electronic medical records of participating clinicians, and direct data collection from community-based organizations focused on their interventions as well as policy and environmental change. (Electronic referral, a cornerstone of the PWTF model, is described in full in Section IV of this report.) With the availability of data, all quality improvement (QI) efforts will be based on measureable targets and grantees will regularly and formally share best practices with each other. They will also be coached by experts to achieve these goals. As a model, PWTF parallels the efforts of the Massachusetts Paul

³ For more information please visit <http://www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/130627-overview-health-care-costs.pdf>

⁴ DPH has previously summarized information about worksite wellness programs in its Model Wellness Guide (<http://www.mass.gov/eohhs/docs/eohhs/wellness-tax-credit/model-wellness-guide.pdf>.)

⁵ A fuller description of the methodology used can be found on pages 11-13 of the Prevention and Wellness Trust Fund 2013 Report.

Coverdell National Stroke Registry, funded by the Centers for Disease Control and Prevention (CDC). Coverdell uses this data-driven, quality improvement approach and has had significant success measuring short-term progress toward achieving national benchmarks for stroke care.

B. Selection and Implementation

Applications for the PWTF Grantee Program were due November 1, 2013 and underwent a two-stage (technical and senior level) review process. At the technical review, each proposal was reviewed based solely on material provided in the application. Proposals were evaluated based on the content and completeness of the application, the demonstration of population need within the proposed service area and their ability to reach the high risk population, their history of partnership, and their experience with clinical data, quality improvement and EHR as part of population health management.

During the senior level review, proposals were evaluated based on criteria deemed critical to both the applicant's ability to begin implementation of interventions within 6-10 months and the likelihood that the applicant could successfully achieve the overall program goals. These criteria were:

- Strength of the lead agency and strength of linkages with partners.
- Quality of the proposed interventions and their alignment with the needs/health risks of the population.
- Readiness to implement proposed interventions.
- Ability to implement a bi-directional e-Referral system.
- Number of priority health conditions being addressed.
- Ability to deliver return on investment.

The geographic distribution of awards was also considered to achieve an equitable distribution of awards across the Commonwealth.

At the end of the review process, nine partnerships were selected for funding and these were divided into two cohorts. Cohort 1 grantees were given a six month capacity-building phase before moving into implementation (March 1 – August 30, 2014) and Cohort 2 grantees were given a ten month capacity-building phase (March 1 – December 31, 2014). Each grantee was funded at approximately \$250,000 for their capacity-building period and the funding for year one implementation ranges from \$1.3 – 1.7 million. Specific funding levels for each grantee, as well as other information about the partnerships' members and selected conditions, can be found in Appendix A of this report.

Cohort 1

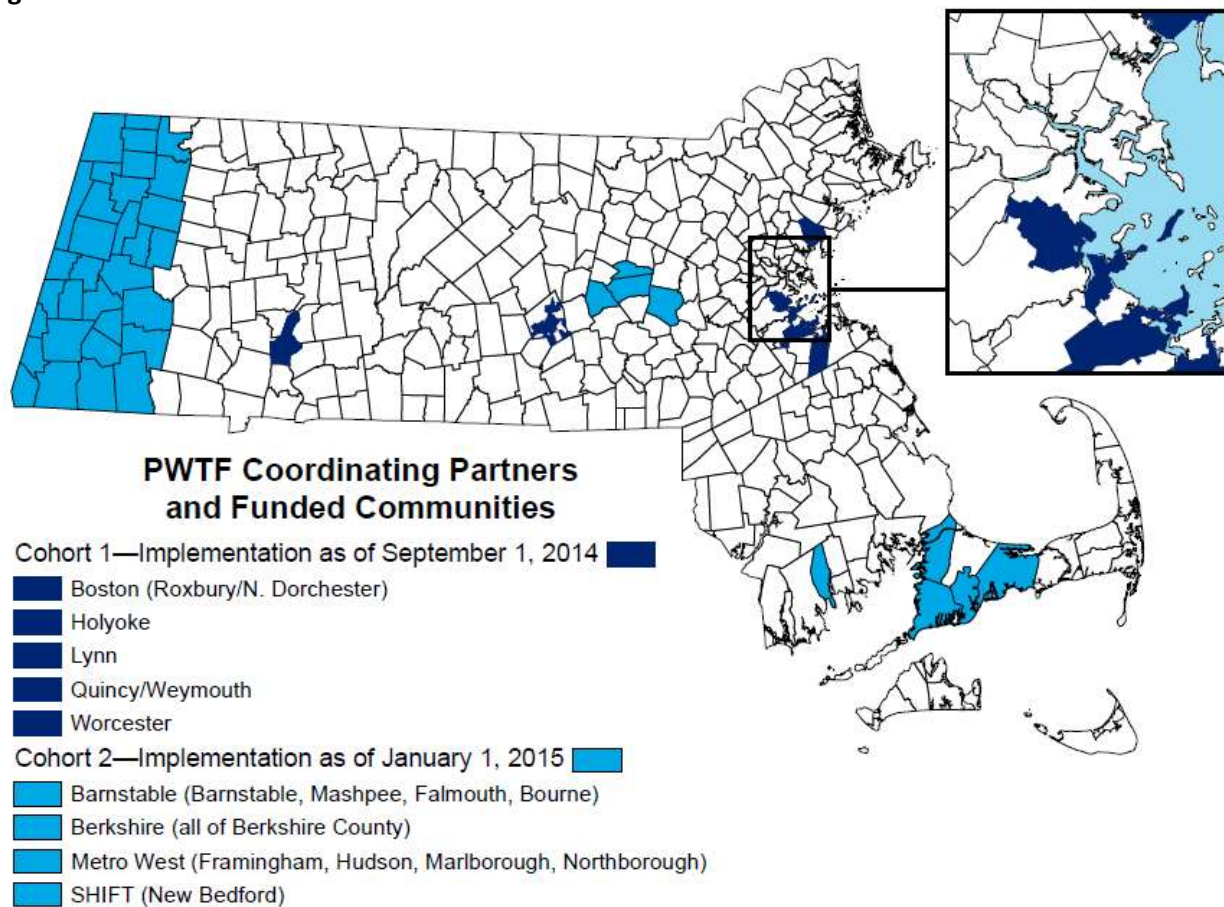
Partnership Name	Coordinating Partner	Towns, Neighborhoods
Boston Partnership	Boston Public Health Commission	North Dorchester, Roxbury
Healthy Holyoke	Holyoke Community Health Center	Holyoke
Lynn Partnership	City of Lynn	Lynn
Quincy-Weymouth Partnership	Manet Community Health Center	Quincy, Weymouth
Worcester Partnership	City of Worcester	Worcester

Cohort 2

Partnership Name	Coordinating Partner	Towns, Neighborhoods
Barnstable County Partnership	Barnstable County Department of Human Services	Barnstable, Mashpee, Falmouth, Bourne
Berkshire Partnership	Berkshire Medical Center	All of Berkshire county
MetroWest Partnership	Town of Hudson	Hudson, Framingham, Marlborough, Northborough
Southeastern Health Initiative for Transformation (SHIFT)	City of New Bedford Health Department	New Bedford

Figure 1 below provides a map showing the geographic distribution of PWTF grantees across the Commonwealth.

Figure 1:



The population within funded communities is 987,422 - approximately 15% of the state population - and includes some of the most racially/ethnically diverse communities in the state, many with large percentages of people living below poverty. For example:

- The Boston Partnership focuses on Roxbury, a community that is 52% Black non-Hispanic and 28% Hispanic/Latino and where more than 1 in 3 families have incomes below poverty level.
- Healthy Holyoke covers the entire city whose population is 48% Hispanic/Latino and where approximately 1 in 3 of its residents are in a household with an income below the poverty level.
- The Lynn Partnership is addressing a community that is 32% Hispanic/Latino and where approximately 1 in 5 people live in a household with an income below the poverty level.
- The city of Worcester is 20% Hispanic/Latino.

The process was also successful in identifying communities with high risk for the priority conditions as shown in Figure 2.

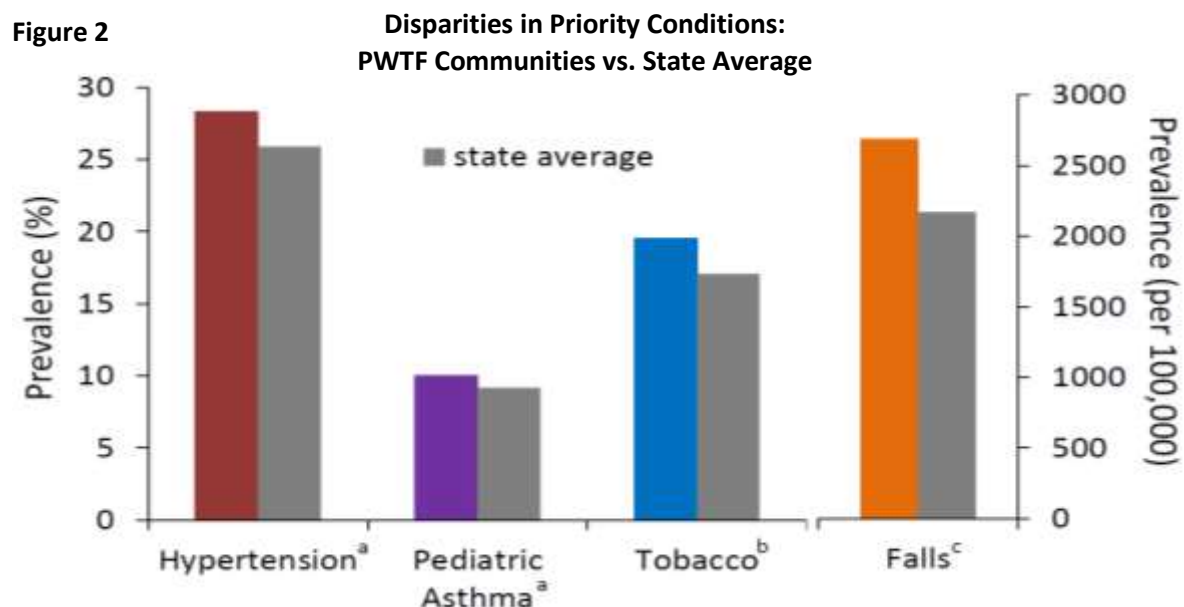


Figure 2. Funded partnerships have greater disease burden than the state as a whole for each priority health condition. Color bars correspond to the condition prevalence averaged across participating communities and grey bars correspond to the state prevalence. Data sources are (a) All Payer Claims Database (APCD), (b) Behavioral Risk Factor Surveillance System (BRFSS), and (c) Acute Hospital Case Mix Databases (Case Mix).

Additionally, grantees opted to address a number of optional conditions based on their area's disease burden and the partners' capacity to deliver evidence-based interventions. Figure 3 provides information about the conditions that grantees identified in their proposals. (Note: as grantees have moved through the capacity-building phase, refined their workplans and focused on those interventions with the highest probability for successful outcomes, there have been and will be future revisions to the conditions/interventions they are addressing.)

Figure 3

Health Conditions Addressed by PWTF Grantees					
Coordinating Partner	Tobacco	Hypertension	Pediatric Asthma	Falls in Older Adults	Other Conditions
Cohort 1					
BPHC		✓	✓	✓	
Holyoke	✓	✓	✓		Obesity, Oral Health
Lynn	✓	✓	✓	✓	
Quincy/Weymouth	✓	✓		✓	Substance Use
Worcester		✓	✓	✓	
Cohort 2					
Barnstable		✓		✓	Diabetes
Berkshire	✓	✓		✓	Diabetes
Metrowest	✓	✓	✓	✓	
SHIFT		✓	✓	✓	Substance Use

Grantee Program Implementation:

Contracts with grantees began on March 1, 2014. As noted above, all grantees began with a capacity-building phase. For Cohort 1 grantees this phase was March 1 – August 31, 2014 and for Cohort 2 this phase was March 1 – December 31, 2014 as these grantees required more time to develop their governance structure and fully develop their workplans and interventions. During the capacity-building phase grantees focused on a number of important foundational activities including: the development and organization of their partnerships, the selection of interventions based on additional guidance from DPH, the design of workflow for the initial e-Referral sites and intervention, and the development of implementation phase workplans and corresponding budgets.

In this reporting year Cohort 1 grantees also moved into the implementation phase, which has involved the initiation of both clinical and community interventions as well as the establishment of an e-Referral linkage between at least one clinical and one community-based organization. Grantees may establish additional linkages, but in year 1, they are only required to link one dyad electronically.

Partnership Development

As noted above, the design of the Grantee Program includes an important model of multi-sector partnerships with the goal of aligning the work of multiple organizations that serve the people in their communities. Each grantee is required to have a minimum of three types of organizations in their partnership. These include clinical organizations (community health centers, hospitals, substance abuse treatment organizations, visiting nurse associations (VNAs), physician practices, and health systems), municipal or other organizations (city departments of public health, regional planning agencies, school

districts) and community-based organizations (YMCAs, Councils on Aging, immigrant and refugee organizations). This triad of client-serving organizations increases the coordination that can lead to improved health outcomes while decreasing the likelihood of patients falling through the cracks during referral and transition. In addition, it serves to offer a broader menu of services in varied settings that could accommodate people in community-based environments where they may feel more comfortable or is more convenient.

Each partnership has a governing body that includes representatives from all or most of the partner organizations in their project. DPH's guidance in the development of these leadership committees was based on a philosophy of shared leadership and responsibility for fiscal, model, and quality improvement frameworks. The role of the coordinating partners is one of administrative and fiscal oversight, partnership-wide communication, and coordination of the group's activities. The coordinating partner organization needs to be able to manage the funding from DPH and in turn, pay the remaining partners as their sub-contractors. The coordinating partners have an equal say in all decisions made by their partnership leadership team.

Each partnership has subcommittees that have been created based on the conditions that the partnership selected. Subcommittees also include a focus on specific interventions, e-Referral, evaluation, and community health workers. The DPH PWTF team has guided the development of this infrastructure through provision of tools, templates, and technical assistance on budget planning and development, but has not mandated a specific model. (See section "Grantee Support and Technical Assistance" for a description of the guidance that has been provided by DPH.)

Evidence-Based Interventions: Tiering the Interventions

In order to guide grantees as they refined their intervention selection for their chosen health conditions, DPH performed a detailed examination of the health conditions and interventions proposed by each partnership, as well as the anticipated reach of these interventions and at-risk populations. DPH sought input from several teams of experts to assist in the analysis of interventions that would ensure the greatest potential for achieving the outcomes defined in the legislation. These experts included:

- A DPH cross-bureau team of internal subject matter experts focused on priority and optional health conditions, as well as health equity and specific strategies such as the use of community health workers;
- A team of academic subject matter experts in each health condition convened by one of the external evaluation partner organizations, Harvard Catalyst;
- Disease-specific content experts at CDC were consulted to ensure that interventions and data measures align with CDC-funded efforts; and
- Social Finance US, a nonprofit organization that is dedicated to mobilizing investment capital to drive social progress through the development of Social Impact Bonds (SIBs) assisted in the analysis of the interventions with the greatest potential for Return on Investment (ROI).⁶

As a result of these consultations, DPH staff developed a tiering system of evidence-based interventions. The plan for creating three tiers of interventions was approved by the Commissioner on March 27, 2014. The approved plan was presented during a summit convening these experts and grantees held on March 28, 2014 as well as reviewed and discussed at the PWAB meeting on June 19, 2014. This three-tiered approach for interventions was based on a set of three criteria: access to data to demonstrate outcomes, evidence base for clinical impact, and likelihood of producing ROI.

⁶ DPH contracted with Social Finance US to assess each intervention with respect to the potential for a return on investment. This analysis resulted in a report that contributed to an additional prioritization of interventions chosen for the PWTF. While there are unanswered questions as to the relevance of an investment possibility in the communities in which DPH has PWTF grantees, DPH will continue to explore this issue as the project moves forward as a possible mechanism for ongoing sustainability.

- **Tier 1 interventions** are those for which there is straightforward access to data, a strong evidence base for clinical impact, and a high likelihood of a positive ROI.
- **Tier 2 interventions** are those for which there is an evidence base; however, either data availability, evidence-base for clinical improvements, or evidence for a positive ROI were not as strong as for Tier 1 interventions.
- **Tier 3 interventions** are those for which there is little or no access to data in order to demonstrate a direct health impact, a minimal evidence base for clinical improvements, and/or little likelihood of ROI in the 3.5 years of funding.

In order to increase the likelihood of demonstrating impact across grantees and thus achieving the outcomes defined in the legislation, grantees have been encouraged to select the highest tier of interventions available for each health condition. *All grantees are required to select at least one Tier 1 intervention for each priority health condition proposed.*

Another critical component of the PWTF as outlined in Chapter 224 is to “develop a stronger evidence-base of effective prevention programming.” Tier 2 interventions are an opportunity for grantees to implement interventions which show promise in their ability to reduce the prevalence of these health conditions and contain the growth of health care costs. DPH will provide support, but on a more limited basis (limited technical assistance, time during learning sessions, and evaluation tools and support) for Tier 3 interventions, on which grantees are permitted to spend a maximum of 5% of their budgets.

A significant aspect of demonstrating ROI is the ability to draw conclusions about the impact of activities across most or all of the grantees. Therefore, in addition to having the strongest evidence base, all Tier 1 interventions are for priority conditions, while evidence-based interventions for optional conditions are listed as Tier 2.

Tier 1

Clinical Interventions	Community Interventions
<ul style="list-style-type: none"> • Asthma - Care Management for High-Risk Asthma Patients • Hypertension – Implementation of Evidence-Based Guidelines for Diagnosis and Management of Hypertension • Falls - Comprehensive Clinical Multi-Factorial Fall Risk Assessment • Tobacco – Implement USPSTF Recommendations for Tobacco Use Screening and Treatment 	<ul style="list-style-type: none"> • Asthma - Home-Based Multi-Trigger, Multi-Component Intervention • Hypertension - Chronic Disease Self-Management Programs (CDSMP) • Falls - Home Safety Assessment and Modification for Falls Prevention

Tier 2

Clinical Interventions	Community Organizations
<ul style="list-style-type: none"> • Asthma - Asthma Self-Management in Primary Care • All optional health condition interventions listed in the RFR (<i>except cross-cutting interventions such as clinical QI and CDSMP that have already been placed in Tier 1 for priority conditions</i>): 	<ul style="list-style-type: none"> • Asthma - Comprehensive School-Based Education Programs, School-Based Multi-Trigger, Multi-Component Environmental Improvement • Tobacco - Promoting Smoke Free Environments • Hypertension - Self-Measured Blood Pressure Monitoring w/Additional

<ul style="list-style-type: none"> * Screening, Brief Intervention and Referral to Treatment (SBIRT) * Fluoride Varnish to Reduce Dental Caries * Pharmacist Interventions to Control Diabetes * Weight Management in the Primary Care Setting 	<p>Support</p> <ul style="list-style-type: none"> • Falls – Programs to Address Fear of Falling, Strength and Balance (Matter of Balance, evidence-based Tai Chi), home-based Exercise Programs (i.e. Otago) • Diabetes – Diabetes Prevention Program
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The specific interventions that each grantee has selected to address their chosen health conditions can be found in Appendix B.

Inclusion of Community Health Workers

A progressive aspect of the PWTF model and the partnerships is the integration of Community Health Workers (CHWs) into the clinical and community teams. Every partnership has chosen to hire CHWs who can help support the critical linkage for patients/clients between the clinical and community interventions. CHWs will be crucial in assisting clients/patients in identifying barriers to engagement in care and services and working through those barriers. Additionally, as CHWs are being used by all partnerships, a significant number of CHWs are being hired, trained and supervised in a consistent way that meets guidelines from DPH's Office of CHWs and evidence-informed practices around the country. Through PWTF, as well as other initiatives, Massachusetts has joined the national movement that recognizes the value of CHWs in improving health outcomes and reducing costs. The attention to CHWs in the PWTF is an important opportunity to strengthen this growing evidence base.

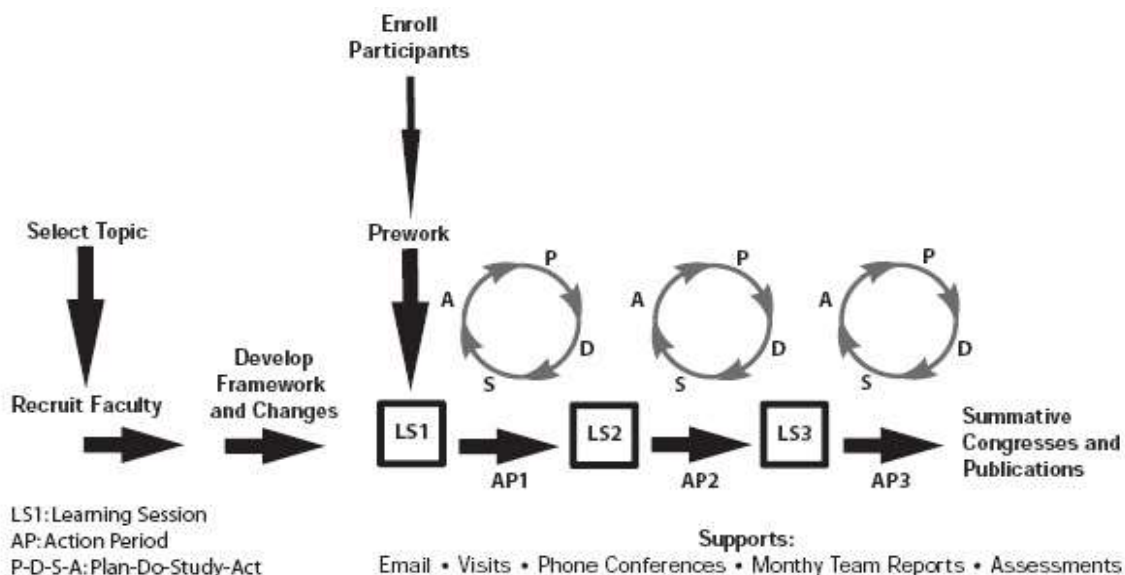
C. Grantee Support and Technical Assistance

Background:

The framework for the quality improvement aspect of the PWTF is the Institute for Healthcare Improvement's (IHI) Collaborative model that uses rapid cycle "tests of change" in a shared learning community to accelerate the pace of improvement. The PWTF grantees will be conducting small tests of change using the Plan-Do-Study-Act (PDSA) method within their own partnerships and will also have the opportunity to share and learn from other PWTF teams at statewide learning sessions. The goal of the IHI Collaborative model is to facilitate and accelerate improvement through shared learning of others' successes and failures from tested changes on the same topic area.

Figure 4 below provides an overview of the key aspects of the IHI Collaborative model that includes: quarterly learning sessions; action periods between the learning sessions when teams are conducting PDSA cycles; and on-going supports for teams from TA coaches.

Figure 4. Institute for Healthcare Improvement Collaborative Model



The PWTF DPH staff includes three team members who serve as technical assistance (TA) coaches each with specific and complementary areas of expertise:

- Patricia Daly is a registered nurse with over 40 years of experience as a healthcare provider and clinical expert for multiple public health programs. Ms. Daly has extensive experience in chronic disease prevention and control as well as in implementing quality improvement programs.
- Lissette Blondet is another TA coach with over 20 years of experience in community health and with community health workers (CHWs). She developed one of the first CHW training programs in the United States. She is a strong champion for linking and integrating the clinical and community domains of healthcare for improved outcomes.
- Laura Coe is the TA Team Lead and has experience implementing a quality improvement program that also used the IHI model for healthcare collaboratives. She is a Certified Professional in Healthcare Quality (CPHQ) and worked for over seven years with clinical teams to implement QI initiatives to improve care.

Together these three TA coaches bring a wealth of knowledge to support the grantees with program implementation and are responsible for a number of technical assistance activities.

Technical Assistance Program Components

i. Coaching Visits

The TA team conducts “Coaching Visits” with all sites at least twice per year. During the Capacity-building phase, these visits focused on analyzing work flows, represented in algorithms, for each health condition. During and after the visit, the TA team coached the condition-specific workgroup members to fine-tune specific aspects of their interventions to ensure fidelity to best practices and true integration of clinical and community services. The “hands-on” approach of the Coaching Visits continues during the implementation phase. The TA team meets with subcommittees to solve issues encountered during implementation. Data collected quarterly by the evaluation team will be reviewed by the TA team and workgroups to identify opportunities for improvement. QI methodology will then

be used to set up plans for workgroups to work on specific factors that might be contributing to the problem and track progress over time. PDSA cycles will be conducted and reported on to assess progress.

ii. Training

DPH has contracted with various training institutes, professional organizations, and subject matter experts to train staff in the nine community partnerships on skills and topics relevant to their roles and their selected interventions. Trainings are held regionally or statewide and seek to enhance organizational and individual capacity to implement interventions in all priority chronic conditions. Training vendors include the Healthy Living Center for Excellence, the University of Massachusetts, the Boston Public Health Commission, and the Maine Chronic Disease Program. Training areas include, but are not limited to, CHW Core Competencies, community-based interventions for falls (Matter of Balance, evidence-based Tai Chi), chronic disease self-management programs (CDSMP), accuracy of blood pressure measurement, and QI methods.

iii. Learning Sessions

As described above and based on the IHI model, learning sessions are being held quarterly and serve as the cornerstone of the in-person shared learning opportunities during the first two years. To date there have been three learning sessions (June 3, September 11, and December 2, 2014). The next two are scheduled for March 5 and June 11, 2015. Several different formats are offered during the full-day training and include: didactic plenary sessions, panel sessions, interactive group exercises, small discussion-based breakout sessions by clinical condition, and networking small group sessions. Presentations are made by external subject matter experts, DPH PWTF staff, as well as by partnership staff involved in various aspects of program implementation. These sessions provide an opportunity for teams to learn from each other about successes or promising practices, challenges, and strategies to address those challenges. There were over 130 attendees at the learning session on September 11, 2014 and overall the evaluation results were positive. Over 84% of respondents indicated that the program enhanced their knowledge and/or skills and 89% responded that the learning objectives for the session were met.

In addition to learning sessions, monthly training webinars are conducted on various topics ranging from clinical condition-specific content (e.g. components of a pediatric asthma CHW home visit) to program management-related areas (e.g. developing a program budget).

Technical Assistance Tools and Resources

i. Communication

In order to ensure communication between DPH and all members of the nine partnerships as well as to encourage communication among grantees, DPH has created a program webpage and webpages for each of the partnerships through SharePoint. The webpages have several functions that facilitate program management including a shared calendar and the ability to share and edit documents to manage version control. The DPH program page serves as the repository for all PWTF materials, trainings, best practice models, grant requirements, etc. General resources including publications, sample tools, and guidelines are posted by topic as well. Each condition folder has a discussion board that can be used to promote interaction among partnerships.

In addition, the site allows all partnerships to exchange information about their programs and the progress of their interventions. A weekly electronic newsletter is sent to all partnerships and provides information about upcoming events and grant deliverables.

ii. Toolkits

To facilitate system-wide improvements to achieve the goals of the PWTF, DPH developed resource “toolkits” that are available on SharePoint. The toolkits support community and clinical team

members to deliver care and services consistent with national guidelines and recommendations. The toolkits provide a roadmap for grantees to identify patients with the priority condition, provide evidence-based care to manage illness and reduce risk, and refer patients to appropriate resources in the community to support self-management.

Clinical teams will use population health registries from their electronic health records to identify and track patients with the priority conditions and to identify subgroups of patients likely to benefit from interventions. Community-based organizations will use data to track the percent of clients referred for services, enrolled in and completing programs. Population health data for both clinical and community partners will be stratified by gender, age, race/ethnicity, preferred language, disability, and/or comorbid conditions to identify populations at highest risk and with disparate outcomes.

Included in each toolkit is a change package: a menu of evidence-based strategies or concepts with specific actionable items that teams can choose from to test for improvements. By setting aims, defining measurement, finding promising ideas for change, and testing those ideas in real work settings, teams will identify and share best practices to achieve the PWTF goals of improved health and health outcomes as well as healthcare cost containment.

Lastly, the grantees have access to internal (DPH) and external (via Harvard Catalyst) subject matter experts (SMEs). DPH expects to develop at least five unique Learning Collaboratives (LC): one on each of the priority conditions and one on CHWs. These LCs will be comprised of clinical and community SMEs and clinical and community leads from each partnership focused on that topic. Over time these groups should become self-sustaining and could assess gaps and develop tools or resources to address them. The LCs will meet in-person during each learning session and will likely have phone or web-based meetings outside of the learning sessions.

D. DPH Staffing and Infrastructure to Administer Grantee Program

In addition to the TA coaches, the DPH PWTF staff includes an administrative team, project evaluators, and a field team.

The Administrative Team's primary responsibilities include: coordinating long term strategic planning, preparing all written reports, coordinating quarterly learning session logistics, developing and managing budgets and contracts, and planning and convening of PWAB meetings. In addition to the PWTF Program Manager, the administrative team includes one full-time Program Coordinator along with two contractors providing logistic, writing and planning support. The administrative team also coordinates with other internal DPH departments and contractors including content experts, data and evaluation staff/contractors, administration and finance staff, and legal staff.

The Evaluation Team is responsible for coordinating and planning evaluation processes, and organizing, sharing, and analyzing data and other information (toolkits, learning session content) among staff and grantees. This team includes a broad team of external evaluators and subject matter experts from the following institutions: Social Finance US, Northeastern University, Harvard Catalyst, Harvard School of Public Health, University of Massachusetts Medical School, John Snow Institute, and the Massachusetts League of Community Health Centers.

The Field Team, which is comprised of the TA coaches as well as the e-Referral staff, are responsible for providing all quality improvement coaching and technical assistance to PWTF grantees, and identifying best practices and suggesting content and speakers for learning sessions. The field team is also responsible for monitoring and sharing progress on benchmarks and indicators, identifying toolkits and QI frameworks, and conducting training to help grantees progress to outcome goals. (This team relies on

external expert faculty advisors - for identifying meaningful outcome and process measures and learning sessions - and internal DPH subject matter experts for content expertise.) The e-Referral staff are responsible for providing the technical and workflow support to partnerships so that they are able to establish bi-directional e-Referral between clinical and community partners.

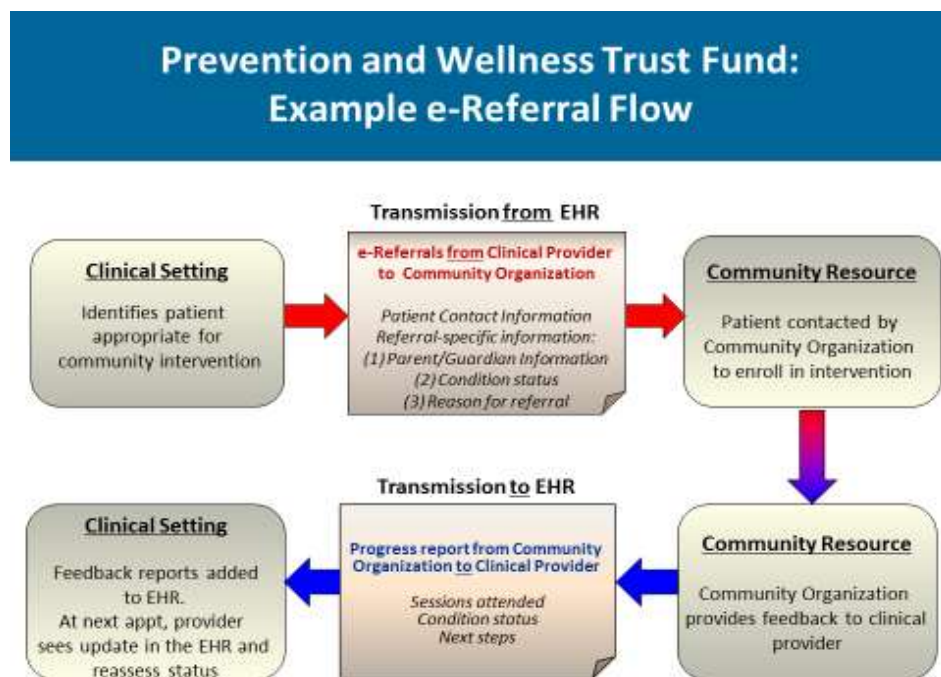
In the next year, DPH will be working to provide additional support to grantees through needed improvements to staffing and infrastructure that have been identified in this first full year of implementation. As noted above in this report, the Prevention and Wellness Trust Fund Grantee Program involves nine health conditions in three intervention domains being conducted by nine partnerships that include 6-18 partners *each*. Grantees need support not only in creating strong partnerships and developing workplans, but in developing budgets, designing intervention workflows, establishing clinical decision supports, training staff in quality improvement techniques, training staff in the evidence-based interventions, onboarding for e-Referral, developing data sharing agreements, and more. DPH leadership has identified a need to expand on the existing staff and have already added a consultant to better support e-Referral needs and will be adding at least one additional person with clinical quality improvement expertise to assist the grantees.

IV. ELECTRONIC REFERRAL

Electronic Referrals from Clinical Sites to Community Resources

PWTF grantees are tasked with establishing electronic linkages between clinical sites and community-based organizations within their partnership. This linkage will take the form of an e-Referral initiated by a clinical provider and sent through their EMR or EHR to a community-based organization that offers an appropriate intervention for a given patient. The community-based organization then contacts the patient/client to explore interest and enrolls the patient in the community intervention. After engagement in the intervention, the community-based organization sends a feedback report containing agreed upon patient information back to the originating clinical organization via the e-Referral system. This electronic referral and communication system not only documents referrals and improves communications between the two (or more) organizations on behalf of a patient, but also serves as a way to document and evaluate the health outcomes of community-based, health related interventions in an efficient new way. This is an important tool for community-based organizations to demonstrate their effectiveness reaching and positively impacting their patients.

Figure 5. e-Referral Flow



Throughout the year, grantees have made considerable strides in establishing e-Referrals. This is in large part due to the foundation developed by grantees who also received support through the Commonwealth's State Innovation Model (SIM) grant award from the Centers for Medicare and Medicaid Services (CMS); two of the entities receiving SIM-funded support are also PWTF grantees. Through the SIM grant, the e-Referral team worked closely with the Executive Office of Health and Human Services' Information Technology Division and the Massachusetts Health Information Exchange (HIE) to enable the hosting of e-Referral software and Secure File Transfer Protocol (SFTP) of e-Referral messages. The team also engaged athenahealth and NextGen, two EMR vendors, to integrate the e-Referral data needs into their existing systems.

The e-Referral work and processes developed by the two joint SIM/PWTF grantees are serving as models for the remaining PWTF sites as they conduct their e-Referral work. One of these dual grantees is currently sending live e-Referrals from a community health center to a community-based organization, and will be expanding to additional community-based organizations in early 2015. The other is still in testing, but anticipates sending e-Referrals in January 2015.

Two additional PWTF sites have been actively and successfully sending e-Referrals. The remaining five partnerships, which are at various stages of the onboarding process, should be sending and receiving e-Referrals by the end of fiscal year 2015.

The PWTF team prioritized the clinical sites for onboarding based on their cohort and EMR vendor; partners in Cohort 1 with NextGen as their EMR are scheduled first. This is due to Cohort 1's faster timeline and because the technical solution for integration was already completed for NextGen through the SIM grant. The PWTF team is also prioritizing connections with an eye toward ensuring each partnership has at least one established clinical site-to-community-based organization e-Referral connection. After each partnership has established this initial e-Referral linkage, additional clinical-community dyads will be on-boarded across all grantees. Although these additional connections are not grant requirements, all grantees are interested in expanding their e-Referral connections beyond their initial dyad. As with the initial e-Referral connections, these additional linkages will be prioritized based on EMR vendor, allowing the PWTF and e-Referral teams to streamline the IT solutions.

Community-based organizations will use the e-Referral Gateway (eRG), a web-based system requiring only an internet browser, to receive e-Referrals from clinical sites and to send feedback reports. One clinical site will also be using the eRG, because their EMR platform is changing in early 2015. As such, DPH will wait until this clinical site's new EMR is established and tested before integrating PWTF e-Referral into their EMR, and the eRG provides a viable option prior to integration.

Organizations sending and receiving e-Referrals are required to draft and execute a legal agreement between one another to address confidentiality and security issues involved in sending of patient/client referrals and information. Although DPH does not provide legal guidance on these documents, they tend to take the form of a Memorandum of Understanding (MOU) or Business Associates Agreement (BAA). All executed referral agreements are posted on SharePoint so that other partnerships can use those as a starting point for drafting their own agreements.

In response to grantee needs and taking into account lessons learned from the SIM grant, the PWTF and e-Referral teams developed a series of materials to support the e-Referral onboarding process. The central tool is the e-Referral "Steps to Go Live Check-List." This check-list details the steps, discussions, and decision points community-based and clinical organizations must focus on to prepare for establishing e-Referral linkages with one another. The DPH teams work closely with grantees using this document as a guide, marking progress and providing TA as required. In addition, DPH has also developed an e-Referral introductory presentation to engage all partners and allow them to begin the e-Referral process from the same knowledge base. The team has also developed a glossary, which is particularly helpful for community-based organizations that are often unfamiliar with e-Referral terms, as well as a Frequently Asked Questions (FAQ) document that is updated continually and posted on the PWTF SharePoint website.

Given DPH's focus on developing and supporting an integrated e-Referral connection for each partnership, the bulk of the work outlined in the check-list will be completed by partnerships independently. Upon completing the check-list, grantees will reach out to DPH, and discussions for providing eRG access will begin.

Looking toward 2015, the PWTF and e-Referral teams will continue to work with grantees to track referral and feedback volume, using PDSA cycles to revise and redirect as needed. The support materials will continue to be revised as grantees progress, and DPH will also work with partnerships to expand their e-Referral capabilities beyond the initial clinical-community dyad. Grantees have expressed significant enthusiasm about the potential of e-Referral and would ideally like to increase the linkages to multiple community and clinical organizations as well as between community-based organizations. Community-based organizations are also interested in expanding the usage to initiate the referral from the community to a clinical site.

V. EVALUATING THE PREVENTION AND WELLNESS TRUST FUND

The goals of the Prevention and Wellness Trust Fund (PWTF) are to reduce the incidence of preventable health conditions, reduce the overall cost of health care for the people of Massachusetts and to develop a strong evidence base of effective prevention programming. Chapter 224, the legislation that created the PWTF, states that “a commission⁷ on prevention and wellness shall” evaluate the effectiveness of activities funded through the grant, including the extent to which the programs have addressed the goals set in the legislation for prevalence, health disparities, and health care costs.

Determining the impact of the PWTF interventions will rely on three key factors:

- linkages across data sets;
- utilization rates of evidence-based interventions that are high enough to yield measureable effects when populations are compared; and
- sufficient time for changes in behavior to lead to clinical improvements and cost reductions.

Without the ability to link clinical data to claims and community data, it will be nearly impossible to create plausible comparisons to the PWTF grantee sites. Furthermore, these comparisons will be especially difficult to construct because the health care environment in Massachusetts is rich with new payment models, new healthcare delivery models, and new insurance benefits provided via the Affordable Care Act. Isolating the impact of interventions funded by PWTF would be difficult under any circumstances. In the current environment of healthcare experimentation, any thoughtful evaluation plan must include links across data sets. Otherwise, a large number of alternative explanations could be put forth to explain any positive results that may be seen.

High utilization of PWTF interventions is also essential for the success of the program and for the evaluation. Unless clinical and community domains collaborate to deliver a substantial number of interventions, it is unlikely that there will be measureable behavior change. Without measureable behavior change, there can be no clinical improvement nor cost reduction attributable to the PWTF. Fortunately, the design of the PWTF program increases the chances of realizing measureable change.

While the goals for the PWTF are ambitious, the program was designed from the outset to increase the likelihood that the legislation’s goals would be met. For example, the program targets high need areas thus increasing the chances of reaching individuals with chronic conditions or those who were at risk of incurring substantial health care costs. Moreover, a hierarchy or tiering system of interventions was developed, as described in section IIIB (page 10), to ensure that all grantees would direct a majority of their funds to those interventions with the highest likelihood of demonstrating measureable outcomes.

In addition, as described in section IIIC (pages 12-15), all partners from all sites are required to participate in a QI collaborative. While Chapter 224 established a clear direction for the PWTF, the goals set forth in the legislation can be adequately evaluated only at the end of the funding period. To keep the program moving forward, it is important for grantees to focus on positive changes from the beginning of project until the end. Thus, a QI framework was employed so all partners could examine change through PDSA cycles. For the PWTF, data literally drives the change.

Finally, time is required for lifestyle changes to take hold. The costly chronic conditions and health risks targeted by the PWTF will not be altered after a single visit to a clinical provider, community organization, or community health worker. The data gathered for the PWTF evaluation must display

⁷ The Commission on Prevention and Wellness was consolidated with the Prevention and Wellness Advisory Board in the fiscal year 2015 state budget through outside sections 136, 194, and 250. This consolidation added four new members to the Prevention and Wellness Advisory Board: the House and Senate Chairs of the Joint Committee on Health Care Financing and the House and Senate Chairs of the Joint Committee on Public Health.

changes that occur gradually over time. The analytic model, therefore, will look for slowly growing improvements following clinical or community interventions. These will be detected by two types of comparisons.

First, analysts will look for comparison communities in Massachusetts that have similar demographic and health risk profiles to the nine PWTF grantees. When possible, trends for PWTF and comparison communities will be examined from several years before PWTF funding began through 2017. If PWTF interventions have been effective, changes in behavior, improvements in clinical measures, reductions in expected health care costs, and improvements in health equity measures will be greater in PWTF communities than in the comparison areas.

Second, comparisons will be made at the individual level. Models will be developed to estimate health behavior changes and clinical improvements for individuals living in the PWTF service areas. These models will be based on historical patterns seen across a number of data sets. For example, the program will look at the reduced likelihood of heart attacks following improvements in hypertension or for quitting smoking. As with the community comparisons, analysts will look for larger than expected changes over time in behavior, improvements in clinical measures, reductions in expected health care costs, and improvements in health equity measures.

The specific analytic models have yet to be determined. A procurement for an outside evaluator was released in late 2014 and will be selected by the end of January 2015. While an external evaluator has yet to be chosen, it is certain that data linkages, utilization rates, and the comparisons described above will play a pivotal role in measuring the effectiveness of the PWTF interventions.

Appendix C provides additional detail on the baseline demographic and health status for the nine PWTF service areas.

Activities Supporting Quality Improvement

Data collected from participating sites has already begun to inform continuous quality improvement efforts within clinical and community organizations. To support this QI in the clinical domain, DPH receives either encounter-level patient data or aggregate counts of patients stratified by age, gender, race, ethnicity, and preferred language. The clinical encounter-level data contains information from each patient visit (encounter), including diagnoses, test results, medications, patient demographics, etc. Aggregate data from additional clinical sites will allow DPH to calculate partnership-level process and outcome measures. In clinical settings, the process and outcome measures will be centered on screening, diagnosing, referring to programs in community settings, and ultimately clinical outcomes. To support QI in the community domain, DPH will receive either encounter-level data from a specialized database or aggregate counts of clients stratified by age, gender, race, ethnicity, and preferred language. The community encounter-level data contains information from each client visit (encounter), including referral source, time to contact, and program enrollment and completion status. In community settings, the process and outcome measures will be centered on client contact, program enrollment, program completion, and sending feedback reports to clinical settings. In both domains, DPH will provide technical assistance to support data collection (technology and workflow), data quality, and evaluation of progress toward benchmarks in process and outcome measures.

To protect patient privacy, DPH receives a limited data set without direct identifiers. This applies to encounter-level data from both clinical and community settings. Encounter-level data from clinical settings is transmitted securely through secure file transfer protocols approved by the Privacy and Data Access Office and the Executive Office of Health and Human Services. All encounter-level data is stored in secure folders and accessed only by DPH evaluators working on the PWTF. Data transmission and storage in this manner is compliant with DPH's Confidentiality and Privacy and Procedures and the Health Insurance Portability and Accountability Act (HIPAA).

VI. WORKSITE WELLNESS INITIATIVE

A. Understanding Worksite Wellness

The majority of adults spend a significant number of their waking hours at work. Physical activity, healthy eating, stress management and tobacco avoidance and cessation are essential in lowering the risk of developing chronic diseases. Promoting a culture of health in workplaces provides opportunities for employees to change their behaviors in an effort to prevent and/or manage chronic health conditions such as obesity, type 2 diabetes, heart disease, cancer and stroke.

Once largely stand-alone enhancements, worksite wellness initiatives are most effective when fully integrated within workplaces and made available to employees and their families. The most comprehensive worksite wellness programs address occupational health and safety hazards as well as risk factor prevention to create a worksite environment that is healthier for employees and enables them to more easily engage in healthy behaviors.

According to the 2014 Massachusetts Worksite Health Improvement Survey, “Creating a Culture of Health,” there are common factors of a wellness program that, if adopted, can lead to improved impact and results. “Successful” wellness programs encourage and support employee participation, provide a supportive culture and environment for employees to engage in healthy behaviors, use data to develop a plan for program design, implementation and measurement, and implement best practices in the field of health promotion. These programs share the same seven benchmarks tailored to meet the unique needs of the business organization. These benchmarks have been established in worksites of various sizes to drive wellness programming. Worksites should strive to integrate these elements into their worksite wellness efforts to help build and sustain worksite wellness efforts.⁸

Worksite Wellness best practices are categorized in these main topic areas:

1. Visible Leadership Commitment
2. Strategic Planning
3. Supportive Organizational Culture
4. Program Design and Intervention Selection
5. Discovery and Needs Assessment
6. Community Resources
7. Data and Evaluation Management

Massachusetts has a long history of supporting worksite wellness efforts. In April 2008, DPH surveyed a random sample of worksites to assess their practices with regard to promoting and protecting employee health and well-being within their organizations. The data from this study helped inform the development of the Working on Wellness program, a one-year training and technical assistance program that guided 60 organizations through the process of developing an infrastructure of wellness in their workplaces.

B. The Planned Initiative

PWTF funds will allow DPH to expand the scope of the previous Working on Wellness program, and provide seed funding to a much larger group of businesses to support wellness programs. The goal is to reach 450 worksites that will participate in a year-long training program, as part of three cohorts with staggered start dates. The businesses will receive training and TA on comprehensive workplace wellness program development in the form of webinars, group TA calls, and participation in an online learning community which will include resource sharing, self-guided learning modules with case studies and

⁸ MA Worksite Health Improvement Survey, 2014 – “Creating A Culture of Health”

success stories, and access to TA. Training and TA will be provided to ensure eligible businesses meet all criteria for the Massachusetts Wellness Tax Credit (but seed funding will not be an eligible expense for the credit). The amount of seed funding will be dependent upon the number of employees in the business, with a cap to be determined by DPH in collaboration with the selected vendor, and will be contingent upon certain participatory and outcome benchmarks (e.g., must attend a certain number of webinars and group TA calls, completion of health risk assessment with a minimum percentage of employee participation, etc.).

Targeted recruitment of small businesses and those with representation from the low-wage workforce will expand worksite wellness to nontraditional participants.

Accomplishments to date include completion of the conceptual design of the training program and development of the procurement. With the release of the procurement in early January the goal is to have a vendor selected and a contract in place early in 2015. DPH will oversee services provided to ensure alignment with PWTF goals and outcomes. After vendor selection is completed, the details for worksite recruitment and identification of benchmarks for funding will be finalized, with a goal for business recruitment to begin in early summer, 2015.

VII. THE PREVENTION AND WELLNESS ADVISORY BOARD

The Prevention and Wellness Advisory Board, established in Section 60 of Chapter 224, is charged with informing the plans for the expenditure of PWTF funds.

In 2014, the legislature introduced a proposal to streamline Chapter 224 by consolidating the existing Prevention and Wellness Advisory Board (established in Section 60 and seated in 2013) and the as yet un-appointed Commission on Prevention and Wellness (established in Section 276 of Chapter 224). This proposal was adopted in the fiscal year 2015 Budget through outside sections 136, 194 and 250.

This consolidation adds four new members to the Prevention and Wellness Advisory Board (PWAB/Advisory Board):

- the House and Senate Chairs of the Joint Committee on Health Care Financing
- the House and Senate Chairs of the Joint Committee on Public Health

The members of the PWAB are:

Governor-Appointed Positions	
Qualification	Board Member
Public Health Economics	David Hemenway, PhD Harvard School of Public Health
Public Health Research	Stephenie C. Lemon, PhD University of Massachusetts Medical School
Health Equity	Vacant*
Local Board of Health (population over 50,000)	Paula Johnson, MD, MPH Chair, Boston Public Health Commission
Local Board of Health (population less than 50,000)	Heidi Porter MPH, REHS, RS Bedford Director of Public Health
Health Insurance Carrier – position 1	MaryLynn Ostrowski, PhD Health New England
Health Insurance Carrier – position 2	Cathy Hartman, MS Blue Cross/Blue Shield
Consumer Health Organization	Susan Servais, BA, CAE Massachusetts Health Council
Hospital Association	Peter Holden, MD Jordan Health Systems, Board member of Mass. Hospital Association
Statewide Public Health Organization	Rebekah Gerwitz, MA Massachusetts Public Health Association
Interest of Businesses	Keith Denham, BS Cohn Reznick, LLP
Public Health or School Nurse	Karen Regan, RN, BSN Town of Norwood

Administrator of an Employee Assistance Program	Robert Bruce Cedar, EdD CMG Associates
Association of Community Health Workers	Lisa Renee Holderby-Fox served until October 3, 2014 ^{**}
Ex-officio Positions	
Commissioner, Department of Public Health	Cheryl Bartlett, RN, Chair (until December 12, 2014, then designee Carlene Pavlos)
Secretary, Executive Office of Health and Human Services	Ashlie Brown, designee
Executive Director, Center for Health Information and Analysis	Lori Cavanaugh, designee
Legislative Positions	
Joint Committee on Healthcare Financing	Senator James T. Welch, Chair Joint Committee on Health Care Financing House Chair, Joint Committee on Health Care Financing ^{***}
Joint Committee on Public Health	Senator John F. Keenan, Chair Joint Committee on Public Health Representative Jeffrey Sanchez, Chair Joint Committee on Public Health

* This position has never been appointed.

** The seat representing a Community Health Worker organization was vacated in October by Lisa Renee Holderby-Fox who left her position as the Executive Director of Massachusetts Association of Community Health Workers (MACHW). MACHW has nominated a new candidate for this seat.

*** The House chairmanship of this committee was vacant at the time it was statutorily added to the PWAB in 2014. Once the House of Representatives appoints a new chair (expected early 2015), that person will assume this seat.

Section 60 of Chapter 224 also delineates the responsibilities of the PWAB. The Advisory Board is responsible for making recommendations to the Commissioner of DPH on the following:

- Administration and allocation of the Prevention and Wellness Trust Fund
- Establishing evaluation criteria
- Reporting annually to the legislature on its strategy for administration and allocation of the fund

As a result of the recent statutory changes and the consolidation of the PWAB with the Commission on Prevention and Wellness, the Advisory Board is also responsible for assuring an evaluation of the Prevention and Wellness Trust Fund, including analysis of:

- (i) the extent to which the program impacted the prevalence of preventable health conditions;
- (ii) the extent to which the program reduced health care costs or the growth in health care cost trends;
- (iii) whether health care costs were reduced and who benefited from the reduction;
- (iv) the extent to which workplace-based wellness or health management programs were expanded and whether those programs improved employee health, productivity and recidivism;

- (v) if employee health and productivity were improved or employee recidivism was reduced, the estimated statewide financial benefit to employers;
- (vi) recommendations for whether the program should be discontinued, amended or expanded and a timetable for implementation of the recommendations; and
- (vii) recommendations for whether the funding mechanism for the fund should be extended beyond 2016 or whether an alternative funding mechanism should be established.

The findings of this evaluation will be due to the House and Senate Ways and Means Committees and the Joint Committee on Public Health by January 31, 2017.

PWAB Meeting Themes and Highlights

To accomplish its multiple obligations, the PWAB has met three times in 2014 (June 19, October 2, and December 11). Agendas, materials and minutes of all Advisory Board meetings are posted at <http://www.mass.gov/eohhs/gov/newsroom/open-meeting-notice/dph/prevention-and-wellness-advisory-board.html>.

The first meeting of the year was scheduled for March 13, during the PWTF grantee kick-off event; however, there was not a quorum of members available to hold a meeting at that time.

The June 19 meeting focused on updating the PWAB about the progress of the Grantee Program with a review of the grantees and the conditions and interventions they have selected. DPH staff presented the technical assistance plan for grantees which is designed to provide them the support needed to be successful in both the capacity-building and implementation stages of the project. Evaluation staff shared results and measures from an initial grantee survey which provided baseline data for each partnership. Initial plans for the worksite wellness initiative were also shared with the PWAB to solicit feedback on the design.

The second PWAB meeting on October 2 was designed with three objectives. The first was to discuss the passage of the outside sections in the state budget which consolidated the PWAB with the Commission on Prevention and Wellness. The resulting new members were introduced and welcomed to the Advisory Board. The second objective of the meeting was to continue to update Advisory Board members on the progress of the Grantee Program. Toward this end, PWAB members were engaged in a more thorough discussion of the technical assistance and quality improvement model being utilized in the Grantee Program. The TA coaches from the Department's PWTF staff were introduced to the Advisory Board and responded to members' questions about the grantees' progress. Advisory Board members were also given a demonstration of the e-Referral system that has been developed by the Department and is a cornerstone for implementing the PWTF model as well as evaluating it. Staff demonstrated the process of a community-based organization receiving a referral from a clinical site and how these referrals are managed within the electronic system. The third objective of the meeting was to discuss plans for the overall evaluation of the PWTF. The Director of the Department's Office of Data Management and Outcomes Assessment discussed plans for a two part process beginning with a requested Letter of Intent and then, based on the results of the first stage, soliciting full applications from a few selected applicants. PWAB members were invited to participate in a meeting on October 31 with grantees to discuss this procurement as well as to participate in the selection process (barring a conflict of interest).

The final meeting of the year, on December 11, focused on a review and discussion of the annual report. Members, who had been provided with a draft of the report in advance of the meeting, were asked for comments and suggestions to strengthen and focus the report. The meeting also included a review of the evaluation activities to date and a lively discussion about how to reach full Advisory Board member engagement.

The statutory changes expanding the membership of the Advisory Board, as well as the tremendous range of expertise represented in its membership, create opportunities for engaging the PWAB that have not yet been fully tapped. In the coming year, DPH staff will offer PWAB members a range of options for participation in PWTF activities, from ongoing engagement in the evaluation design and implementation, to supporting efforts to inform stakeholders about the PWTF and potential strategies for sustainability.

VIII. EXPENDITURES TO DATE

Over the four-year life of the program, the Prevention and Wellness Trust will receive \$57 million. The Prevention and Wellness Trust Fund budget for the four years allocates no more than \$8,550,000 (or 15%) for administrative and evaluation expenses including the staff described in section IIIC, contractors to support evaluation, technical assistance, IT infrastructure, and other support for funded partnerships. A total amount of \$42,750,000 has been budgeted to fund grants and \$5,700,000 for worksite wellness activities.

Through December 15, 2014, the PWTF has received \$31,604,078.12 with current expenses totaling \$7,938,494.91. The funds expended to date include \$666,415.33 (2% of the total received to date) for staffing-related costs and \$261,335.92 for consultant and logistical support for the listening sessions, bidders' conference and RFR. This constitutes 3% of funds received to date and 2.1% of total funds anticipated over the four-year life of the program.

The estimated budget for the first year of implementation activities (July 1, 2014 – June 30, 2015) is currently estimated at \$19,590,384.00 of which \$15,220,541.00 will support community grants, \$1,890,000.00 will be expended on worksite wellness technical assistance and activities, and \$2,479,843.00 (13% of estimated FY15 budget) will be spent on staff support, technical assistance and evaluation planning. DPH anticipates an annual budget of \$14,250,000.00 for the remaining two years of the PWTF.

APPENDIX A

Massachusetts Prevention and Wellness Trust Fund

Grantee Highlights 2014

Cohort 1:

**Boston Partnership
Healthy Holyoke
Lynn Partnership
Quincy/Weymouth
Worcester Partnership**

Cohort 2:

**Barnstable PWTF
Berkshire PWTF
MetroWest Partnership
Southeastern Health Initiative for Transformation (SHIFT)**

Boston Partnership

Coordinating Partner Organization: Boston Public Health Commission
 Capacity-Building Budget Allocation: \$249,251.00
 Annual intervention Budget Allocation: \$1,781,025.00
 Cohort: 1

Conditions and Interventions Selected:	Hypertension	Pediatric Asthma	Falls Prevention
Clinical	Evidence-based guidelines for hypertension screening	Care management for high-risk asthma patients	STEADI clinical risk assessment
Community	Chronic Disease Self-Management Program (CDSMP)	Comprehensive school-based education programs Comprehensive daycare-based education programs	Tai Chi Matter of Balance Home safety Assessment and Modification/ Habilitation

Community Partners	Clinical Partners	Other Partners	Municipal Partners
ABCD/ Head Start Boston Senior Home Central Boston Elder Services Ethos	BMC Injury Prevention Center Bowdoin St. CHC Codman Square CHC Dimock Center Dorchester House Multi-Service Center Harbor Health Services Harvard St. Neighborhood Health Center Whittier St, CHC	Health Resources in Action (HRiA) MA Health Quality Partners (GB AF4Q)	Boston Emergency Medical Services Boston Public Health Commission Boston Public Schools Boston Commission on the Elderly

Partnership Highlights

Through PWTF, the Boston Public Schools (BPS) and community clinic sites are partnering to create a streamlined system of comprehensive care coordination for high-risk children with asthma. The BPS hosts 50,000 students, approximately 10,000 of which have asthma. To streamline communication and to build capacity, each site will identify an asthma champion to serve as the primary contact for information exchange. Additionally, BPS has identified four Asthma Nurse Leads who will provide technical assistance, training and support to all BPS nurses throughout their 110 sites and will facilitate information exchange between BPS sites and partner clinics.

<u>Grantee comment</u>
<i>“With PWTF, we have formed partnerships with CBO’s and CHC’s to help us improve the health of our most vulnerable residents in Boston. Focusing on Roxbury and North Dorchester where these disease rates are among the highest in the Commonwealth, we are working to improve the health and safety of people with pediatric asthma, hypertension and at risk for elder falls. Disease prevalence and health costs have been high in these communities because of decades of inequitable access to resources and services. We can now offer community-based programs, coordinated care, and build long-term alliances among health care and human service providers and community residents.” – Member of the leadership team in Boston Partnership</i>

Healthy Holyoke

Coordinating Partner Organization: Holyoke Community Health Center

Capacity-Building Budget Allocation: \$250,000.00

Annual intervention Budget Allocation: \$1,378,901.00

Cohort: 1

Conditions and Interventions Selected:	Hypertension	Pediatric Asthma	Tobacco
Clinical	Evidence-based guidelines for hypertension screening	Care management for high risk asthma patients Asthma self-management in primary care	USPSTF screening guidelines
Community	Self-measured blood pressure monitoring w/additional support	Home-based multi-trigger, multi-component intervention School-based multi-trigger, multiple component intervention	Promoting smoke-free environments Tobacco cessation counseling
Conditions and Interventions Selected	Obesity (optional) w/Diabetes and Hypertension		Oral Health (optional)
Clinical	Weight management in primary care		Screenings for dental disease and malocclusion
Community	Environmental approaches in the community to address obesity YMCA –USA diabetes prevention program		screenings for dental disease and malocclusion- mobile dentistry

Community Partners	Clinical Partners	Municipal Partners
Greater Holyoke YMCA Holyoke Housing Authority Holyoke Public Schools	Holyoke Health Center Holyoke Medical Center River Valley Counseling Center Western Mass Physicians Associates	City of Holyoke

Partnership Highlights

The Holyoke partnership has a high level of engagement and technical expertise, led by Holyoke Medical Center's successful experience implementing Health Information Exchange (HIE), that they are leveraging to create a bi-directional electronic referral system linking clinical and community partners for community-based interventions. This process is being piloted for electronic referrals from Holyoke Health Center and Holyoke Medical Center to the YMCA for management of hypertension, diabetes and obesity. As the technological system becomes fully operational, it will be expanded to include other community-based organizations and interventions. This system will be the first in the state to streamline e-referrals in this way and will serve as a model for other PWTF Partnerships.

<u>Grantee comment</u>
"Holyoke is fortunate to have an integrated community of healthcare providers. We are excited by the opportunity presented by the Prevention and Wellness Trust Fund to expand these partnerships with our clinical and community partners through innovative interventions and a bi-directional electronic referral system that we believe will help improve the health of the Holyoke community and reduce overall health care costs." - Jay Breines, Chief Operating Officer, Holyoke Health Center

Lynn Partnership

Coordinating Partner Organization: City of Lynn
 Capacity-Building Budget Allocation: \$250,000.00
 Annual intervention Budget Allocation: \$1,785,000.00
 Cohort: 1

Conditions and Interventions Selected:	Hypertension	Pediatric Asthma	Falls Prevention	Tobacco
Clinical	Evidence-based guidelines for hypertension screening and management	Asthma management and care coordination	Comprehensive clinical fall risk assessment	USPSTF Tobacco Counseling and Interventions
Community	Chronic Disease Self-Management Programs (CDSMP) Self-measured blood pressure monitoring with additional supports	Home-based multi-trigger, multi-component intervention	Matter of Balance Home safety assessment and modification/habilitation	Referral to Quitworks Promoting smoke-free environments

Community Partners	Clinical Partners	Municipal Partners	Other Partners
Greater Lynn Senior Services Massachusetts Coalition for the Homeless	Lynn Community Health Center	City of Lynn Lynn Public Schools	Metropolitan Area Planning Council LHAND Lynn Public Schools

Partnership Highlights

The City of Lynn is working to enhance an integrated patient management model between Lynn Community Health Center (CHC) and the Greater Lynn Senior Services (GLSS) using a bi-directional electronic referrals and communication system. This model will be used to integrate the clinical and home-based components of the comprehensive fall risk assessment for older adults, as well as to offer routine community blood pressure monitoring through kiosks located in several venues throughout the city. The City of Lynn also has a unique partnership among the Lynn Public Schools, the Massachusetts Coalition for the Homeless and Lynn CHC to implement the home-based, multi-trigger, multicomponent interventions for asthma management. These well-integrated partnerships will serve as model programs for linking community and clinical services.

Grantee comment

“The community partners in Lynn, in conjunction with the City's Health Department, are excited to be moving into the implementation phase of the PWTF this fall. Currently the Coalition is focusing largely on falls prevention and the electronic referral system that will support best-practice interventions. The LCHC is gearing up its Quality Improvement staff to join the multidisciplinary clinical teams already in place at the Health Center in identifying and referring all eligible patients for falls interventions. Overall, the Coalition is a strong and highly functioning team. We are excited to see the PWTF succeed in Lynn, producing cost savings as well as improved, sustainable clinical outcomes for our clients through best practice interventions.” – MaryAnn O'Connor, Coordinating Partner, Lynn Partnership

Quincy-Weymouth Partnership

Coordinating Partner Organization: Manet Community Health Center
 Capacity-Building Budget Allocation: \$250,000.00
 Annual intervention Budget Allocation: \$1,785,000.00
 Cohort: 1

Conditions and Interventions Selected:	Hypertension	Tobacco	Falls Prevention	Substance Abuse (optional)
Clinical	Evidence-based guidelines for HTN screening	USPSTF screening guidelines Tobacco cessation counseling	STEADI clinical risk assessment	SBIRT – Screening, Brief Intervention, Referral to Treatment
Community	Chronic Disease Self-Management Program (CDSMP)	Promoting smoke-free environments Tobacco cessation counseling	Matter of Balance Tai Chi Home safety assessment and modification/habilitation	SBIRT in the community

Community Partners	Clinical Partners	Municipal Partners	Other Partners
Bay State Community Services South Shore YMCA South Shore Elder Services	South Shore Hospital Quincy Medical Center/Steward Manet CHC	City of Quincy Health Dept. Town of Weymouth	South Shore Workforce Investment Board

Partnership Highlights

The Quincy and Weymouth Partnership is working closely with the Health Departments in the City of Quincy and Town of Weymouth to improve and formalize the process for client referrals for clinical and community-based services for falls risk, chronic disease self-management, and behavioral health services. Many referrals are made to the South Shore Elder Services for a comprehensive assessment of the individual's needs and either enrollment in their services or an additional referral as needed. Secondary referrals are tracked to better understand and respond to the needs of underserved populations. The goal is to ensure that clients have health insurance coverage and are connected to a medical home for appropriate follow up. Their unique approach involves the coordination by the Health Departments with the SSES and clinical sites (Manet Community Health Center, South Shore Hospital, and Quincy Medical Center) to streamline and optimize referrals for this high-risk population.

Grantee comment

"The Quincy Weymouth Prevention and Wellness Trust Fund Partnership is enthusiastically, appreciatively and thoughtfully moving forward as a collaborative and bringing to life this ground-breaking opportunity with the Massachusetts Department of Public Health for our shared community. The Quincy Weymouth Partnership joins partners across municipal, community-based and clinical platforms with the most vital and essential partner--the residents from across Quincy and Weymouth who inspire the work. It is frankly, our shared honor to come together to help improve, extend, and fortify lives for residents through: enhanced communication, the delivery of high quality, intelligent, and accessible interventions that will contest chronic illness, improve health outcomes while simultaneously reducing health care costs and expenditures," - John J. Holiver, Chief Executive Officer, Manet Community Health Center

Worcester Partnership

Coordinating Partner Organization: City of Worcester
 Capacity-Building Budget Allocation: \$212,791.00
 Annual intervention Budget Allocation: \$1,784,053.00
 Cohort: 1

Conditions and Interventions Selected:	Hypertension	Pediatric Asthma	Falls Prevention
Clinical	Evidence-based guidelines for hypertension screening	Care Management for High-Risk Asthma Patients Asthma Self-Management in Primary Care	STEADI clinical risk assessment
Community	Chronic Disease Self-Management Programs Self-Measured Blood Pressure Monitoring with Additional Support	Home-based multi-trigger, multi-component intervention Comprehensive School-based Education Programs	Tai Chi Matter of Balance Home Safety Assessment and Modification/Habilitation

Community Partners	Clinical Partners	Municipal Partners	Other Partners
Central Mass AHEC Community Legal Aid MA Audubon Mosaic Cultural Complex Worcester Child Development and Head Start Program	UMass Memorial Medical Center Edward M Kennedy CHC Family Health Center of Worcester, Inc.	City of Worcester Worcester Public Schools Worcester Senior Center	UMass Medical School Fallon Health

Partnership Highlights

The Worcester partnership is planning a comprehensive approach to address pediatric asthma. They plan to use CHWs to identify high risk pediatric asthma patients who would be eligible for a Home-Based Multi-Trigger, Multi-Component Intervention. Through these home assessments and interventions they will be able to identify and rectify triggers in the home. In addition, they plan to work with the public school system to educate school nurses and parents on pediatric asthma management. These evidence-based interventions have the potential to improve control of high risk children, reduce costly asthma-related Emergency Department visits, and improve the quality of life for asthmatic children and their families. In addition, the Family Health Center in Worcester plans to create a Falls Clinic where they will refer seniors who have been identified as high risk for falls for a comprehensive falls assessment and follow-up. We are eager to learn from them while they develop and implement these novel and innovative approaches.

Grantee comment

"We, in the Worcester Partnership, are thrilled for the opportunity to bring these innovations in healthy living and clinical care to the residents of Worcester. It is our collective goal that Worcester becomes the healthiest city in the Commonwealth by 2020 and our work through the Prevention & Wellness Trust Fund is an important step in that work. We are excited as we begin the implementation phase of the Trust Fund and all that we will do to improve the health of our great City." -Derek Brindisi, Director of the Worcester Division of Public Health, Coordinating Partner

Barnstable Prevention and Wellness Trust Fund

Coordinating Partner Organization: Barnstable County Department of Human Services
 Capacity-Building Budget Allocation: \$236,019.00
 Annual intervention Budget Allocation: \$1,494,638.00
 Cohort: 2

Conditions and Interventions Selected:	Hypertension	Falls Prevention	Diabetes (optional)
Clinical	Evidence-based guidelines for hypertension screening	STEADI Clinical Risk Assessment	Quality Improvement in clinical settings, Pharmacist interventions to control diabetes
Community	Chronic Disease Self-Management (CDSMP)	In-Home Risk Assessment, Matter of Balance	Chronic Disease Self-Management (CDSMP), National Diabetes Prevention Program (DPP)

Community Partners	Clinical Partners	Municipal Partners
YMCA of Cape Cod, Healthy Living Cape Cod Coalition	Community Health Center of Cape Cod Duffy Health Center Harbor Community Health Center/Hyannis	Barnstable County Department of Human Services

Partnership Highlights

The Barnstable Partnership has created a single system of care for patients with chronic conditions. Three independently run community health centers, Duffy Health Center, Harbor Health Cape Cod, and the Community Health Center of Cape Cod, have come together to create a formal network to provide services and referrals to patients who could benefit from an evidence-based chronic disease self-management course or a diabetes prevention course. Through this system of chronic disease care, providers from these health centers refer patients to two community-based organizations - the YMCA and the Healthy Living Cape Cod Coalition--for hypertension and diabetes management programs. Referrals to and from the community health centers are standardized and will become embedded into their EMRs with the assistance of e-Referral.

In addition to hypertension and diabetes, the Barnstable Partnership is planning interventions for falls prevention for those at high risk.

Grantee comment

"Our partnership seeks to extend the patient's medical home and network of care beyond the walls of the clinical setting. Our interventions will assist them in learning how to manage their conditions themselves. By offering PWTF interventions in community-based group settings they will join a motivated community of their peers that will sustain them beyond the classroom." – Vaira Harick, Barnstable County of Human Services, Coordinating Partner.

Berkshire Prevention and Wellness Trust Fund

Coordinating Partner Organization: Berkshire Medical Center
 Capacity-Building Budget Allocation: \$250,000.000
 Annual intervention Budget Allocation: \$1,694,362.80
 Cohort: 2

Conditions and Interventions Selected:	Hypertension	Falls Prevention	Tobacco	Diabetes (optional)
Clinical	Evidence-based guidelines for hypertension screening and management (JNC 8 guidelines)	Implementing comprehensive fall risk assessment (STEADI) in clinical settings	USPSTF tobacco screening guidelines	QI in clinical settings
Community	Self-measured blood pressure with additional supports	Matter of Balance Home safety and modification Home safety check list	Promoting smoke-free Environments Tobacco cessation counseling DPH quit smoking resources	National Diabetes Prevention Program

Community Partner	Clinical Partner	Municipal Partner	Other
Berkshire United Way	Berkshire Medical Center Fairview Hospital	Tri-Town Health Department District Berkshire County Boards of Health	Northern Berkshire Community Coalition Berkshire Regional Planning Commission/ Berkshire Public Health Alliance

Partnership Highlights

Berkshire Medical Center (BMC) has convened a multidisciplinary group of clinical and community partners from across their extensive service area to provide comprehensive support to residents living in the Berkshires. One model program is focused on providing home monitoring blood pressure cuffs. The program is supported by nurses leading individual and group education, counseling and follow up to community members with poorly controlled hypertension. BMC has already shared their extensive knowledge in planning and implementing this evidence-based intervention with other grantees through presentations at PWTF meetings and one-to-one mentoring. Another model will focus on standardizing USPSTF tobacco screening guidelines in the inpatient and outpatient settings. An example of improvement will be to have all cessation providers trained as treatment specialists utilizing the U Mass standards. BMC is also introducing the use of Community Health Workers (CHWs) to support patient engagement in care. The partnership is working closely to identify models to integrate a network of CHWs to work with residents across their geographically diverse and rural areas to build internal capacity to sustain this work in Berkshire County.

Grantee comment

"The PWTF provides us a powerful platform to improve health through the work of the specific interventions and our collaborative work- bringing key players from clinical and community settings together to engage patients and people in improving their health. We believe this process and successful implementation of our initiatives will increase our collective effectiveness and drive improved results for our community." -Ruth Blodgett, Senior VP, Systems Planning & Program Dev't, Berkshire Health System, Coordinating Partner

MetroWest Partnership

Coordinating Partner Organization: Town of Hudson
 Capacity-Building Budget Allocation: \$249,911.00
 Annual intervention Budget Allocation: \$1,732,759.85
 Cohort: 2

Conditions and Interventions:	Hypertension	Pediatric Asthma	Tobacco	Falls Prevention
Clinical	Evidence-based guidelines for hypertension screening and management	Care management for high risk asthma patients Asthma management in primary care	USPSTF tobacco screening and treatment guidelines	STEADI falls risk assessment
Community	CDSMP	Home-based multi-trigger, multicomponent intervention	Promote Smoke-Free Housing Referral to QuitWorks Tobacco cessation counseling	Tai Chi A Matter of Balance Home Falls Prevention Checklist

Community Partners	Clinical Partners	Municipal Partners	Other Partners
Latino Health Insurance Program YMCA of Central MA MetroWest YMCA	Edward M. Kennedy CHC MetroWest Medical Center Charles River Medical Associates	City of Marlborough Town of Framingham Town of Northborough Town of Hudson	Metropolitan Area Planning Council Central MA AHEC

Partnership Highlights

The MetroWest Partnership includes an innovative model of collaboration among four regional Boards of Health: Hudson, Marlborough, Framingham, and Northborough. Working with their community partners including the YMCA and the Latino Insurance Health Program (LIHP), and with their clinical partners, the Edward M. Kennedy Community Health Center in Framingham, MetroWest Medical Center, and Charles River Medical Associates, they are developing strategies to address hypertension, tobacco use, pediatric asthma and falls in the elderly. The MetroWest partnership is developing creative strategies to link clients to primary care by providing limited health services at the Latino Insurance Health Program and using Community Health Workers (CHWs) based in the Boards of Health to engage clients.

Grantee Comment

"The Prevention and Wellness Trust Fund is truly a unique opportunity for clinical, community and municipal partners in MetroWest to work together in a coordinated fashion. While each of us offers important patient/client services, we rarely spend time coordinating those services with one another to ensure they are as effective and efficient as possible. This project will help all of us support patient health, and give clinical providers important feedback about the health related programs and education their patients receive in their community. We know that the community-clinical linkages we establish through the Prevention and Wellness Trust Fund will benefit our patients/clients well beyond the length of the grant." – Sam Wong, Director of Public and Community Health Services, Town of Hudson, Coordinating Partner

Southeastern Health Initiative for Transformation (SHIFT)

Coordinating Partner Organization: City of New Bedford Health Department
 Capacity-Building Budget Allocation: \$250,000.00
 Annual intervention Budget Allocation: \$1,784,801.10
 Cohort: 2

Conditions and Interventions Selected:	Pediatric Asthma	Falls Prevention	Substance Abuse (optional)
Clinical	Asthma self-management in primary care	STEADI Clinical Risk Assessment	SBIRT – Screening, Brief Intervention, and Referral to Treatment
Community	Home-based multi-trigger component intervention	Matter of Balance	Enhanced enforcement of alcohol laws; Behavioral Health Network (BHNet)

Community Partners	Clinical Partners	Municipal Partners	Other Partners
Child and Family Services, Inc. Inter-Church Council of Greater NB Positive Action Against Chemical Addiction (PAACA) Seven Hills Behavioral Health Stanley St. Treatment and Resources (SSTAR) YMCA Southcoast	Greater New Bedford Community Health Center Southcoast Health Systems Community Nurse and Hospice	New Bedford Health Department New Bedford Housing Authority	Boston Medical Center (BMC) Injury Prevention UMass-Dartmouth

Partnership Highlights

The SHIFT (Southeastern Health Initiative For Transformation) Partnership in New Bedford has selected as their interventions Pediatric Asthma, Falls Prevention, Substance Use/Mental Health (Behavioral Health) and possibly Hypertension. As part of their Falls Intervention, SHIFT is developing a protocol for primary care practices and community health centers to integrate the STEADI clinical risk assessment, an evidence-based falls assessment, into medical practices. This innovative work flow will shift the burden of conducting the entire assessment from the PCP to various skilled members of the team, including front desk staff, medical assistant, etc. This protocol, spearheaded by nationally known expert on falls prevention, Dr. Jonathan Howland, will include training to Primary Care teams and incorporates QI reviews to ensure quality.

Grantee comment

“The DPH’s PWTF provides the City of New Bedford an unprecedented opportunity to work in tandem with other Massachusetts partnerships to test an innovative and timely approach to health care systems reform, as underscored by the Affordable Care Act. The Commissioner’s vision for the PWTF places Massachusetts at the front of truly transformative health care strategies that emphasize prevention and population health in care delivery. The City of New Bedford is honored to be an awardee of the PWTF program.” – Brenda Weis, Director of Public Health, City of New Bedford, Coordinating Partner

APPENDIX B

**Massachusetts Prevention and Wellness
Trust Fund**

Conditions and Interventions by Grantee

Boston Partnership

			BPHC	Clinical Partners	Community Partners
	Hypertension	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for HTN screening	1	X	Bowdoin St; Codman Sq; Dorchester House; Harbor Health; Harvard St; Whittier	Ethos, Central Boston Elder Services; Boston Senior Home Care; Boston Commission on Elderly Affairs
<i>Community</i>	Chronic Disease Self-Management Programs	1	X	Bowdoin St; Codman Sq; Dorchester House; Harbor Health; Harvard St; Whittier	Ethos, Central Boston Elder Services; Boston Senior Home Care; Boston Commission on Elderly Affairs
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2			
	Pediatric Asthma	Tier	Y		
<i>Clinical</i>	Care Management for High-Risk Asthma Patients	1	X	CHCs: Codman Sq; Dimock; Dorchester House, Harbor Health, Harvard St.	
<i>Community</i>	Comprehensive Day Care-Based Education Programs	3	X	Boston Public School Health Services	Boston Public Schools (BPS); ABCD Head Start, HRiA/PALs; Alliance for Quality Health's Healthier Roxbury
	Comprehensive School-Based Education Programs	2	X	Boston Public School Health Services	Boston Public Schools (BPS); ABCD Head Start, HRiA/PALs; Alliance for Quality Health's Healthier Roxbury
	Falls	Tier	Y		
<i>Clinical</i>	STEADI Clinical Risk Assessment	1	X	Bowdoin St; Dimock; Whittier;	Ethos; Boston Commission on Elderly Affairs; Boston Senior Home Care; Central Boston Elder Services; the City of Boston; Boston Medical Center Injury Prevention Center

<i>Community</i>	Tai Chi	2	X	Bowdoin St; Dimock; Whittier;	Ethos; Boston Commission on Elderly Affairs; Boston Senior Home Care; Central Boston Elder Services; the City of Boston; Boston Medical Center Injury Prevention Center
	Matter of Balance	2	X	Bowdoin St; Dimock; Whittier;	Ethos; Boston Commission on Elderly Affairs; Boston Senior Home Care; Central Boston Elder Services; the City of Boston; Boston medical Center Injury Prevention Center
	Home Safety Assessment and Modification / Habilitation	1	X	Bowdoin St; Dimock; Whittier;	Boston Commission on Elderly Affairs; Boston Senior Home Care; Central Boston Elder Services; the City of Boston; Boston medical Center Injury Prevention Center

Healthy Holyoke Partnership

			Holyoke	Clinical Partners	Community Partners
	Tobacco	Tier	Y		
<i>Clinical</i>	USPSTF Screening Guidelines	1	X	HHC, HMC, WMPA	
<i>Community</i>	Promoting Smoke-Free Environments	2	X		HHA
	Tobacco Cessation Counseling	1	X	HMC, RVCC	
	Hypertension	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for HTN screening	1	X	HHC; WMPA; HMC	YMCA; City
<i>Community</i>	Chronic Disease Self-Management Programs	1			
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2	X	HHC; HMC; RVCC	YMCA
	Pediatric Asthma	Tier	Y		
<i>Clinical</i>	Care Management for High-Risk Asthma Patients	1	X	HMC	
	Asthma Self-Management in primary care	2	X	HHC, WMPA	
<i>Community</i>	Home-Based Multi-Trigger, Multi-Component Intervention	1	X	HHC, WMPA, HMC	HHA, YMCA
	School-based Multi-Trigger, Multi-Component Intervention	2	X		City, HPS

	Comprehensive Day Care-Based Education Programs	3			
	Comprehensive School-Based Education Programs	2			
Optional Conditions					
	Obesity		w/ Diabetes + HTN		
<i>Clinical</i>	Weight management in primary care	2	X	HHC	Let's Move Holyoke 5210
<i>Community</i>	Environmental approaches in the community to address obesity	2	X	HHC; RVCC	YMCA; City; Let's Move Holyoke 5210
	Y-USA Diabetes Prevention	2	X	HHC, WMPA	YMCA, City
	Oral Health	Tier	Y		
<i>Clinical</i>	Fluoride varnish	2	X		
<i>Community</i>	Fluoride varnish, mobile dental screenings and malocclusion	2	X	HHC	HHA, YMCA, HPS

Lynn Partnership

			Lynn	Clinical Partners	Community Partners
	Tobacco	Tier	Y		
<i>Clinical</i>	USPSTF Screening Guidelines	1	X	Lynn Community Health Center	
<i>Community</i>	Promoting Smoke-Free Environments	2	X		MAPC, LHAND, MTCP (Quitworks)
	Tobacco Cessation Counseling	1	X	Lynn Community Health Center	Quitworks, LHAND
	Hypertension	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for HTN screening	1	X	Lynn Community Health Center	
<i>Community</i>	Chronic Disease Self-Management Programs	1	X	Lynn Community Health Center	Greater Lynn Senior Services
	Self-Measured Blood Pressure Monitoring w/Add'l Support	2	X	Lynn Community Health Center	Greater Lynn Senior Services
	Pediatric Asthma	Tier	Y		
<i>Clinical</i>	Care Management for High-Risk Asthma Patients	1			
	Asthma Self-Management in primary care	2	X	Lynn Community Health Center	
<i>Community</i>	Home-Based Multi-Trigger, Multi-Component Intervention	1	X	Lynn Community Health Center	Massachusetts Coalition for the Homeless, Lynn Public

					Schools, LHAND
	School-based Multi-Trigger, Multi-Component Intervention	2			
	Comprehensive Day Care-Based Education Programs	3			
	Comprehensive School-Based Education Programs	2			
	Falls	Tier	Y		
<i>Clinical</i>	STEADI Clinical Risk Assessment	1	X	Lynn Community Health Center	Greater Lynn Senior Services
<i>Community</i>	Tai Chi	2			
	Matter of Balance	2	X	Lynn Community Health Center	Greater Lynn Senior Services
	Home Safety Assessment and Modification / Habilitation	1	X	Lynn Community Health Center	Greater Lynn Senior Services, LHAND

Quincy/Weymouth Partnership

			Quincy/ Weymouth	Clinical Partners	Community Partners
Tobacco			Y		
Clinical	USPSTF Screening Guidelines	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Bay State Community Services; South Shore YMCA; South Shore Workforce Investment Board
	Promoting Smoke-Free Environments	2	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Bay State Community Services; South Shore YMCA; South Shore Workforce Investment Board
Community	Tobacco Cessation Counseling	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Bay State Community Services; South Shore YMCA; South Shore Workforce Investment Board
Hypertension			Y		
Clinical	Evidence-based Guidelines for HTN screening	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; South Shore YMCA; South Shore Workforce Investment Board
Community	Chronic Disease Self-Management Programs	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; South Shore YMCA; South Shore Workforce Investment Board
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2			

	Falls	Tier	Y		
<i>Clinical</i>	STEADI Clinical Risk Assessment	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; South Shore YMCA; South Shore Elder Services
<i>Community</i>	Tai Chi	2			
	Matter of Balance	2	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; South Shore YMCA; South Shore Elder Services
	Home Safety Assessment and Modification / Habilitation	1	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; South Shore YMCA; South Shore Elder Services

Optional Conditions

	Substance Abuse		Y		
<i>Clinical</i>	SBIRT	2	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; Bay State Community Services
<i>Community</i>	SBIRT in Communities	3	X	Manet Community Health Center; South Shore Hospital; Quincy Medical Center	City of Quincy; Town of Weymouth; Bay State Community Services
	Enhanced Enforcement of Alcohol Laws	2			

Worcester Partnership

			Worcester	Clinical Partners	Community Partners
	Hypertension	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for HTN screening	1	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester	Mosaic Cultural Complex
<i>Community</i>	Chronic Disease Self-Management Programs	1	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester	Mosaic Cultural Complex
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester	Mosaic Cultural Complex
	Pediatric Asthma	Tier	Y		
<i>Clinical</i>	Care Management for High-Risk Asthma Patients	1	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester; Plumley Village Health Services; UMass Memorial Pediatric Primary Care; (4 Primary Care Sites); UMass Memorial Pediatric Pulmonology (MD/NP)	Worcester Public Schools/ Head Start, Community Legal Aid
	Asthma Self-Management in primary care	2	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester; UMMHC Plumley Village Health Services; UMass Memorial Pediatric Primary Care; UMass Memorial Pediatric Pulmonology (MD/NP)	Worcester Public Schools/ Head Start, Community Legal Aid

Community	Home-Based Multi-Trigger, Multi-Component Intervention	1	X	Edward M. Kennedy Community Health Center; Family Health Center Worcester; Plumley Village Health Services; UMass Memorial Pediatric Primary Care; (4 Primary Care Sites); UMass Memorial Pediatric Pulmonology (MD/NP)	Worcester Public Schools Head start
	School-based Multi-Trigger, Multi-Component Intervention	2	X	UMass Memorial Pediatric Pulmonology	Worcester Public Schools/ Head Start, Community Legal Aid
	Comprehensive Day Care-Based Education Programs	3			TBD
	Comprehensive School-Based Education Programs	2	X	UMass Memorial Pediatric Pulmonology	Worcester Public Schools/ Head Start, Community Legal Aid
	Falls	Tier	Y		
Clinical	STEADI Clinical Risk Assessment	1	X	Family Health Center Worcester	Fallon Health, Worcester Senior Center
Community	Tai Chi	2	X		Fallon Health, Worcester Senior Center, Central MA AHEC, Elder Services of Worcester
	Matter of Balance	2	X	Family Health Center Worcester	Fallon Health, Worcester Senior Center, Central MA AHEC, Elder Services of Worcester
	Home Safety Assessment and Modification / Habilitation	1	X		Fallon Health, Worcester Senior Center, St. Paul's Elder Outreach, Elder Services of Worcester, Central MA Housing Alliance

Barnstable Prevention Partnership

			Barnstable	Clinical Partners	Community Partners
	Hypertension	Tier	Y		
Clinical	Evidence-based Guidelines for HTN screening	1	X	Community Health Center of Cape Cod, Duffy Health Center, Harbor Community Health Center/Hyannis	
Community	Chronic Disease Self-Management Programs	1	X		Healthy Living Cape Cod Coalition
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2			
	Pediatric Asthma	Tier	Y		
Clinical	Care Management for High-Risk Asthma Patients	1	NA		
	Asthma Self-Management in primary care	2			
Community	Home-Based Multi-Trigger, Multi-Component Intervention	1			
	School-based Multi-Trigger, Multi-Component Intervention	2			
	Comprehensive Day Care-Based Education Programs	3			
	Comprehensive School-Based Education Programs	2			
	Falls	Tier	Y		
Clinical	STEADI Clinical Risk Assessment	1	X	Community Health Center of Cape Cod, Duffy Health Center,	
Community	Tai Chi	2			Healthy Living Cape Cod Coalition
	Matter of Balance	2			Healthy Living Cape

				Cod Coalition
	Home Safety Assessment and Modification / Habilitation	1		Healthy Living Cape Cod Coalition

Optional Conditions

	Diabetes	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for DIABETES screening	1	X	Community Health Center of Cape Cod, Duffy Health Center, Harbor Community Health Center/Hyannis	
<i>Community</i>	Chronic Disease Self-Management Programs	1	X		Healthy Living Cape Cod Coalition
	YDPP (YMCA Diabetes Prevention Program)	1	X		YMCA of Cape Cod

Berkshire County Partnership

PWTF Interventions by Grantees

			Cohort 2		
				Clinical Partners	Community Partners
			Y		
Tobacco			Tier		
Clinical	USPSTF Screening Guidelines	1	X	Berkshire Medical Center & Fairview Hospital	NA
	Promoting Smoke-Free Environments	2	X		Berkshire Public Health Alliance and Tri-Town Health Department
Community	Tobacco Cessation Counseling	1	X		Outpatient programs at Berkshire Medical Center, Fairview Hospital and the Satellite Emergency Facility
Hypertension			Tier	Y	
Clinical	Evidence-based Guidelines for HTN screening	1	X	Berkshire Medical Center & Fairview Hospital	
Community	Chronic Disease Self-Management Programs	1		NA	NA
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2	X	Berkshire Medical Center & Fairview Hospital	Berkshire Public Health Alliance, Tri-Town Health Department and Northern Berkshire Community Coalition
Pediatric Asthma			Tier	Y	
Clinical	Care Management for High-Risk Asthma Patients	1			
	Asthma Self-Management in primary care	2			
Community	Home-Based Multi-Trigger, Multi-Component Intervention	1			NA
	School-based Multi-Trigger, Multi-Component Intervention	2			
	Comprehensive Day Care-Based Education Programs	3			

	Comprehensive School-Based Education Programs	2			
	Falls	Tier	Y		
Clinical	STEADI Clinical Risk Assessment	1	X	Berkshire Medical Center and Fairview Hospital	
Community	Tai Chi	2	X		
	Matter of Balance	2	X		Berkshire Public Health Alliance and Northern Berkshire Community Coalition
	Home Safety Assessment and Modification / Habilitation	1	X		Berkshire Medical Center (via Berkshire Regional Nursing Association)

Optional Conditions

	Substance Abuse		Y		
Clinical	SBIRT	2			
Community	SBIRT in Communities	3			NA
	Enhanced Enforcement of Alcohol Laws	2			
	Obesity				
Clinical	Weight management in primary care	2			NA
Community	Environmental approaches in the community to address obesity	2			
	Y-USA Diabetes Prevention	2			
	Diabetes		Y		
Clinical	QI in Clinical Settings	2	X	Berkshire Medical Center and Fairview Hospital	
	Pharmacist Interventions to Control Diabetes	2			
Community	Chronic Disease Self-Management Programs	2			

	National Diabetes Prevention Program	2	X	Berkshire Medical Center and Fairview Hospital	Berkshire Public Health Alliance, Northern Berkshire Community Coalition
	Oral Health	Tier			
Client	Fluoride varnish	2	NA		
Community	School-based sealant program	2			

MetroWest Partnership

				Clinical Partners	Community Partners
	Tobacco	Tier	Y		
Clinical	USPSTF Screening Guidelines	1	x	EMK CHC (Framingham), MetroWest Medical Center	
Community	Promoting Smoke-Free Environments	2	x		Health Departments: Hudson, Framingham, Marlborough, Northborough
	Tobacco Cessation Counseling	1	x		Health Departments: Hudson, Framingham, Marlborough, Northborough
	Hypertension	Tier	Y		
Clinical	Evidence-based Guidelines for HTN screening	1	x	EMK CHC (Framingham), MetroWest Medical Center	
Community	Chronic Disease Self-Management Programs	1	x		MetroWest YMCA, Latino Health Insurance Program
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2			
	Pediatric Asthma	Tier	Y		
Clinical	Care Management for High-Risk Asthma Patients	1	x	EMK CHC (Framingham)	
	Asthma Self-Management in primary care	2			

Community	Home-Based Multi-Trigger, Multi-Component Intervention	1	x		Framingham Health Department
	School-based Multi-Trigger, Multi-Component Intervention	2			
	Comprehensive Day Care-Based Education Programs	3			
	Comprehensive School-Based Education Programs	2			
	Falls	Tier	Y		
Clinical	STEADI Clinical Risk Assessment	1	x	EMK CHC (Framingham), Charles River Medical Associates	
Community	Tai Chi	2	x		MetroWest YMCA, YMCA of Central MA
	Matter of Balance	2	x		MetroWest YMCA, YMCA of Central MA, Latino Health Insurance Program
	Home Safety Assessment and Modification / Habilitation	1	x		Health Departments: Hudson, Framingham, Marlborough, Northborough

SHIFT: New Bedford Partnership

			SHIFT	Clinical Partners	Community Partners
	Hypertension	Tier	Y		
<i>Clinical</i>	Evidence-based Guidelines for HTN screening	1	X	Greater NB Community Health Center	
<i>Community</i>	Chronic Disease Self-Management Programs	1	X		New Bedford Health Department; NB Housing Authority; YMCA
	Self-Measured Blood Pressure Monitoring w/ Add'l Support	2			
	Pediatric Asthma	Tier	Y		
<i>Clinical</i>	Care Management for High-Risk Asthma Patients	1			
	Asthma Self-Management in primary care	2	X	Greater NB Community Health Center	
<i>Community</i>	Home-Based Multi-Trigger, Multi-Component Intervention	1	X		New Bedford Health Department
	School-based Multi-Trigger, Multi-Component Intervention	2			
	Comprehensive Day Care-Based Education Programs	3			
	Comprehensive School-Based Education Programs	2			
	Falls	Tier	Y		
<i>Clinical</i>	STEADI Clinical Risk Assessment	1	X	Greater NB Community Health Center; Southcoast Health System	

Community	Tai Chi	2			
	Matter of Balance	2	X		Community Nurse and Hospice Care
	Home Safety Assessment and Modification / Habilitation	1			
Optional Conditions					
	Substance Abuse		Y		
	SBIRT	2	X	Greater NB Community Health Center; Southcoast Health System	Greater NB Community Health Center; Southcoast Health System
Clinical	CAGE-AID (Substance use/abuse) and PHQ-9 (Mental Health)	both are SAMHSA evidence based	X	Greater NB Community Health Center; Southcoast Health System	BHNetwork: Stanley Street Treatment and Resources; Seven Hills Behavioral Health; Child and Family Services; Positive Action Against Chemical Addiction; Inter-Church Council
Community	SBIRT in Communities	3	Possible		BHNetwork: Stanley Street Treatment and Resources; Seven Hills Behavioral Health; Child and Family Services; Positive Action Against Chemical Addiction; Inter-Church Council
	BASIS 24 in Communities	devel'd by McLean Hospital, Harvard	X		BHNetwork: Stanley Street Treatment and Resources; Seven Hills Behavioral Health; Child and Family Services; Positive Action Against Chemical Addiction; Inter-Church Council

	Enhanced Enforcement of Alcohol Laws	2	Possible		New Bedford Health Department (with New Bedford Police Dept)
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APPENDIX C

**Massachusetts Prevention and Wellness
Trust Fund
Baseline Data**

Calculating Baselines

DPH used statewide surveillance data and clinical encounter-level data to calculate baselines for improvement. The baselines prevalence of the four priority conditions (hypertension, tobacco use, pediatric asthma, and falls among the elderly) and five optional/co-morbid conditions (diabetes, obesity, oral health, substance abuse, and mental health) were calculated from multiple datasets. The datasets utilized were the US Census 2010, Behavioral Risk Factor Surveillance System (BRFSS), Acute Hospital Case Mix Databases (Case Mix), and the All Payer Claims Database (APCD). DPH used the most current data available at the time of release.

Using multiple datasets allows comparison of different aspects of chronic disease burden in the state. The Behavioral Risk Factor Surveillance System (BRFSS) provides self-report data. The All Payer Claims Database (APCD) provides prevalence of hypertension diagnoses for all patients covered by insurance (public or private). With the Acute Hospital Case Mix Databases (Case Mix), we are able to calculate prevalence of distal outcomes that often result from untreated chronic conditions, such as cardiovascular disease (due to hypertension) and lung cancer (due to smoking). Each data source is described in detail below.

Data Sources and Analysis Methodology

The *US Census 2010* data was obtained from the American Fact Finder website (<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>). Race and ethnicity data for each town and zip code for PWTF-funded communities were calculated from the 2010 Demographic Profile Data tables. Information on socioeconomic status was obtained from the 2008-2012 American Community Survey 5-Year Estimates tables. Partnership-level estimates were then calculated as a weighted average of the estimates from towns or zip codes. The US Census 2010 represents the most accurate and detailed view of demographic characteristics of Massachusetts communities.

The *Behavioral Risk Factor Surveillance System (BRFSS)* is a telephone survey that has been conducted in the state since 1986. The latest available year for analysis was 2013, though some questions are not asked every year. For all calculations we used the latest available data, and we averaged across multiple calendar years (i.e., 2011, 2012, and 2013) where possible. To calculate prevalence at the town or zip code level, we calculated small area estimates, which were weighed by the demographic characteristics (i.e. race, ethnicity, age) of the geographic area. Partnership-level estimates were then calculated as a weighted average of the estimates from towns or zip codes. The BRFSS is a major source of self-report health data in the Commonwealth, and its long history will enable us to compare current and historical trends in health condition prevalence.

The *Acute Hospital Case Mix Databases (Case Mix)* contains patient-level data from hospital inpatient discharges and hospital emergency departments. (Unless otherwise noted, all hospitalization data are from hospital inpatient discharges.) The latest full calendar year for analysis was 2012, and we calculated average rates over the past three years (i.e., 2010, 2011, and 2012). Partnership-level estimates were calculated as a weighted average of town or zip code level estimates.

The *All Payer Claims Database (APCD)* consists of medical, pharmacy, and dental claims for all payers covering Massachusetts residents. The most recent year available for analysis was 2012. We calculated condition prevalence at the town or zip code level using the number of unique patients. Partnership-level estimates were then calculated as a weighted average of the town or zip code prevalence. (Since DPH's access to the APCD was only very recent - September 2014, we were only able to calculate condition prevalence for this report.) Next, we will also use the APCD to calculate baselines for medication adherence and costs in each funded partnership.

The geographic extent of each partnership was determined from the RFR applications and work plans submitted to DPH. The spatial resolution of each geographic area (towns or zip codes) was determined based on this information as well. Three partnerships consist of single towns/cities: Holyoke, Lynn, and SHIFT (New Bedford). Three partnerships consist of multiple towns/cities: Barnstable (Barnstable, Bourne, Falmouth, and Mashpee), MetroWest (Framingham, Hudson, Marlborough, and Northborough), and Berkshire County (Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mount Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, and Windsor). The remaining three partnerships consist of multiple zip codes within towns/cities: Boston (02120, 02119, 02125, 02121, and 02122), Quincy/Weymouth (02171, 02169, 02188, 02189, and 02190), and Worcester (01610, 01608, 01607, 01604, and 01603).

Results

Overall, the average disease burden in funded partnerships was greater than the state average for each priority condition (Figure 1). Participating communities also contain greater percentages of racial and ethnic minorities than the state as a whole (Table 1), and have a more people living below the Federal Poverty Level (Table 2). Baseline prevalences in each community from each data source are presented in Tables 3-11 for each health condition.

Demographics

While funded partnerships overall contain greater percentages of racial and ethnic minorities than the state as a whole, certain communities have the ability to reach specific racial or ethnic minorities that are traditionally underserved by the current health care system. For Black/African American populations, the Boston, Lynn, and Worcester partnerships have much greater percentages than the state average (Table 1). For Hispanic/Latino populations, the Holyoke, Lynn, Worcester, Boston, and SHIFT partnerships have much greater percentages than the state average. The Quincy/Weymouth partnership has the ability to reach Asian populations and the SHIFT and Barnstable partnerships have the ability to reach American Indian/Alaskan Native populations as well.

Participating communities in six funded partnerships have a greater percentage of people living below the Federal Poverty Level: Holyoke, Boston, Worcester, Shift, Lynn, and Berkshire (Table 2). Thus, the Prevention and Wellness Trust Fund has the potential to reduce health disparities for those of low socioeconomic status as well.

Table 1: Race and Ethnicity Population Breakdown in Prevention and Wellness Trust Fund Grantee Communities

Geographic Area	Total Population	White alone (%)	Black or African American alone (%)	American Indian/Alaskan Native alone (%)	Asian alone (%)	Hawaiian Native/Pacific Islander (%)	Hispanic or Latino (any race) (%)
Barnstable	110484	90.77	2.34	0.87	1.25	0.05	2.40
Berkshire County	131219	92.50	2.70	0.20	1.20	0.00	3.50
Boston: N. Dorchester, Roxbury	123279	27.29	43.62	0.62	8.15	0.06	22.12
Holyoke	39880	66.00	4.70	0.80	1.10	0.10	48.40
MetroWest	140035	78.66	3.92	0.24	5.61	0.05	10.38
Lynn	90329	57.60	12.80	0.70	7.00	0.10	32.10
Quincy/Weymouth	118052	76.38	4.56	0.20	14.66	0.02	3.24
SHIFT (New Bedford)	95072	74.50	6.40	1.30	0.90	0.10	16.70
Worcester	90777	64.90	12.35	0.48	7.38	0.06	24.99
Grantee Average	939127	70.67	10.81	0.55	5.59	0.05	14.88
State Average	6547629	80.40	6.60	0.30	5.30	0.00	9.60

Table 1. Communities in PWTF partnerships are more racially and ethnically mixed than the state as a whole. All data is from the US Census 2010.

Table 2: Income Levels for Individuals and Families in Prevention and Wellness Trust Fund Grantee

Communities		
Geographic Area	All families with children <18 whose incomes are less than the Federal Poverty Level (%)	Persons with incomes below Federal Poverty Level (%)
Barnstable	10.28	9.55
Berkshire County	16.60	12.40
Boston: N. Dorchester, Roxbury	34.41	30.15
Holyoke	39.90	30.60
MetroWest	8.93	7.76
Lynn	23.90	20.80
Quincy/Weymouth	11.71	8.97
SHIFT (New Bedford)	27.10	21.60
Worcester	30.08	24.32
Grantee Average	20.49	16.94
State Average	12	11

Table 2. Communities in PWTF partnerships have a greater percentage of people living below the Federal Poverty Level than the state as whole. All data is from the US Census 2010.

Table 3: Hypertension: Prevalence of hypertension and cardiovascular disease by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix CVD prevalence per 100,000	APCD (%)
Barnstable	31.87	2069.8	36.13
Berkshire County	32.68	1798.7	29.38
Boston: N. Dorchester, Roxbury	30.50	1903.9	25.37
Holyoke	37.59	2130.9	30.52
MetroWest	28.79	1507.2	27.20
Lynn	31.62	1738.9	28.14
Quincy/Weymouth	28.74	1962.4	26.59
SHIFT (New Bedford)	34.76	2441.3	32.62
Worcester	28.94	1466.6	28.22
Grantee Average	31.19	1862.7	28.37
State Average	28.78	1670.8	25.91

Table 3. Communities in PWTF partnerships have higher prevalence of hypertension than the state as a whole. CVD = cardiovascular disease. BRFSS prevalence is a small-area estimate generated from the number of respondents between the ages of 18 and 85 that have ever been told they have hypertension averaged across the 2011 and 2013 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients between the ages of 18 and 85 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with any of the following three digits: 401, 402, 403, or 404. APCD prevalence is the proportion of unique patients between the ages of 18 and 85 in the year 2012 for which there is a claim with a diagnosis code beginning with any of the following three digits: 401, 402, 403, or 404.

Table 4: Tobacco Use: Prevalence of tobacco use and lung cancer by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix lung cancer prevalence per 100,000	APCD (%)
Barnstable	15.40	90.72	10.80
Berkshire County	19.13	84.92	10.29
Boston: N. Dorchester, Roxbury	20.70	57.61	8.85
Holyoke	24.98	78.31	12.99
MetroWest	16.37	64.04	10.79
Lynn	22.82	70.26	10.38
Quincy/Weymouth	19.77	88.82	10.67
SHIFT (New Bedford)	28.31	102.27	12.01
Worcester	25.35	55.83	10.86
Grantee Average	19.56	77.34	10.69
State Average	17.08	69.73	9.86

Table 4. Communities in PWTF partnerships have higher prevalence of tobacco use than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondents over age 18 that have smoked at least 100 cigarettes in their lifetime and are now smoking regularly averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients over the age of 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with any of the following digits: 162.9, 490, 491, 492, 493, 494, 495, or 496. APCD prevalence is the proportion of unique patients over the age of 18 in the year 2012 for which there is a claim with a diagnosis code beginning with any of the following digits: 162.9, 490, 491, 492, 493, 494, 495, or 496.

Table 5: Pediatric Asthma: prevalence of pediatric asthma and emergency department visits due to pediatric asthma by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix ED visits per 100,000	APCD (%)
Barnstable	15.42	711.36	6.94
Berkshire County	15.18	648.48	8.95
Boston: N. Dorchester, Roxbury	16.33	2091.85	12.61
Holyoke	16.52	2420.80	11.00
MetroWest	15.31	801.98	9.04
Lynn	15.76	1277.33	10.30
Quincy/Weymouth	14.41	762.91	10.23
SHIFT (New Bedford)	15.39	798.48	10.28
Worcester	15.06	1535.91	8.46
Grantee Average	15.65	1401.67	10.04
State Average	15.03	768.19	9.19

Table 5. Communities in PWTF partnerships have higher prevalence of pediatric asthma than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondent parents of children between the ages of 2 and 18 that have ever been told they have asthma averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of emergency department (ED) encounters of patients between the ages of 2 and 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with 493. APCD prevalence is the proportion of unique patients between the ages of 2 and 18 in the year 2012 for which there is a claim with a diagnosis code beginning with 493.

Table 6: Falls among older adults: prevalence of falls by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix falls per 100,000	APCD (%)
Barnstable	7.51	2159.12	6.16
Berkshire County	6.46	1931.44	7.15
Boston: N. Dorchester, Roxbury	3.79	4677.15	6.95
Holyoke	6.59	2514.72	8.46
MetroWest	4.85	2261.43	7.41
Lynn	4.46	2350.66	11.90
Quincy/Weymouth	5.03	2752.34	9.56
SHIFT (New Bedford)	6.09	2455.11	11.21
Worcester	3.98	5237.73	7.78
Grantee Average	5.34	2690.86	8.28
State Average	4.96	2170.17	8.11

Table 6. Communities in PWTF partnerships have higher prevalence of falls than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondents over age 65 that have experienced a fall with an injury in the past three months averaged across the 2006, 2008, and 2010 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients over the age of 65 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with any of the following digits: E880, E881, E882, E883, E884, E885, E886, E888, E957, E968.1, E987, or V15.88. APCD prevalence is the proportion of unique patients over the age of 65 in the year 2012 for which there is a claim with a diagnosis code beginning with any of the following digits: E880, E881, E882, E883, E884, E885, E886, E888, E957, E968.1, E987, or V15.88.

Table 7: Diabetes: prevalence of diabetes by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix diabetes prevalence per 100,000	APCD (%)
Barnstable	7.80	145.63	8.11
Berkshire County	8.13	163.23	8.54
Boston: N. Dorchester, Roxbury	10.45	378.33	10.57
Holyoke	15.06	320.09	9.50
MetroWest	6.82	129.95	8.63
Lynn	10.66	232.82	10.54
Quincy/Weymouth	7.83	193.90	8.27
SHIFT (New Bedford)	11.27	362.90	11.62
Worcester	9.36	213.92	10.40
Grantee Average	7.99	155.18	8.46
State Average	7.33	157.16	7.96

Table 7. Communities in PWTF partnerships have prevalence of diabetes than the state as a whole for survey (BRFSS) and claims (APCD) data.. BRFSS prevalence is a small-area estimate generated from the number of respondents between the ages of 18 and 75 that have ever been told they have diabetes averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients between the ages of 18 and 75 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with 250. APCD prevalence is the proportion of unique patients between the ages of 18 and 75 in the year 2012 for which there is a claim with a diagnosis code beginning with 250.

Table 8: Obesity: prevalence of obesity by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix obesity prevalence per 100,000	APCD (%)
Barnstable	21.59	109.52	5.54
Berkshire County	23.56	84.60	6.67
Boston: N. Dorchester, Roxbury	29.44	127.68	12.24
Holyoke	38.08	74.91	9.64
MetroWest	25.27	120.15	9.60
Lynn	31.50	122.34	11.77
Quincy/Weymouth	20.32	103.34	10.26
SHIFT (New Bedford)	30.98	202.71	9.12
Worcester	28.78	79.69	12.59
Grantee Average	38.08	74.91	9.64

State Average **23.08** **96.05** **8.12**

Table 8. Communities in PWTF partnerships have higher prevalence of obesity than the state as a whole in survey (BRFSS) and claims (APCD) data. BRFSS prevalence is a small-area estimate generated from the number of respondents over age 18 that have a body mass index (BMI) of 30 or greater averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients over the age of 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with 278. APCD prevalence is the proportion of unique patients over the age of 18 in the year 2012 for which there is a claim with a diagnosis code beginning with 278.

Table 9: Oral Health: prevalence of poor dental health, dental caries, and emergency department visits due to dental caries by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix ED visits per 100,000	APCD (%)
Barnstable	6.50	49.72	0.29
Berkshire County	7.50	42.24	0.26
Boston: N. Dorchester, Roxbury	10.37	51.20	0.63
Holyoke	11.73	84.07	0.37
MetroWest	6.76	11.29	0.21
Lynn	10.80	6.98	0.41
Quincy/Weymouth	9.16	22.00	0.27
SHIFT (New Bedford)	10.40	95.81	0.46
Worcester	9.87	42.62	0.61
Grantee Average	11.73	84.07	0.37
State Average	7.75	20.65	0.27

Table 9. Communities in PWTF partnerships have higher prevalence of pediatric dental caries than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondents under age 18 that have not been to the dentist in the past 12 months averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of emergency department (ED) encounters of patients under the age of 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with 521. APCD prevalence is the proportion of unique patients under the age of 18 in the year 2012 for which there is a claim with a diagnosis code beginning with 521.

Table 10: Substance Use: prevalence of substance use by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix substance use prevalence per 100,000	APCD (%)
Barnstable	17.78	14.38	7.27
Berkshire County	19.63	15.47	7.56
Boston: N. Dorchester, Roxbury	18.85	23.12	7.74
Holyoke	19.25	12.48	8.49
MetroWest	17.74	13.11	6.55
Lynn	17.03	26.04	10.23
Quincy/Weymouth	18.54	22.81	7.75
SHIFT (New Bedford)	16.71	30.13	10.15

Worcester	19.18	26.72	9.63
Grantee Average	17.75	25.97	8.60
State Average	19.88	15.39	6.42

Table 10. Communities in PWTF partnerships have higher prevalence of substance use-related hospitalizations (Case Mix) and claims (APCD) than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondents over age 18 that have had 5 or more drinks in one sitting in the past month averaged across the 2011, 2012, and 2013 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients over the age of 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with any of the following digits: 291, 292, 303, 304, 305, 965.0, 965.00, 965.01, 965.02, 965.09, E850.0, E850.1, or E850.2. APCD prevalence is the proportion of unique patients over the age of 18 in the year 2012 for which there is a claim with a diagnosis code beginning with any of the following digits: 291, 292, 303, 304, 305, 965.0, 965.00, 965.01, 965.02, 965.09, E850.0, E850.1, or E850.2.

Table 11: Mental health: prevalence of mental health disorders by PWTF partnership across four data sources

Geographic Area	BRFSS (%)	Case Mix prevalence per 100,000	APCD (%)
Barnstable	6.08	739.38	27.75
Berkshire County	6.84	2639.33	28.21
Boston: N. Dorchester, Roxbury	11.27	951.34	23.49
Holyoke	14.33	2716.02	29.15
MetroWest	6.70	1108.17	27.50
Lynn	11.47	1721.57	27.60
Quincy/Weymouth	6.90	1065.89	28.03
SHIFT (New Bedford)	14.15	1459.64	28.73
Worcester	11.08	1877.65	27.59
Grantee Average	9.13	1485.88	27.44
State Average	7.46	1039.13	26.35

Table 11. Communities in PWTF partnerships have higher prevalence of poor mental health than the state as a whole. BRFSS prevalence is a small-area estimate generated from the number of respondents over age 18 that have displayed any symptoms of depression by the Patient Health Questionnaire-2 (PHQ-2) averaged across the 2006, 2008, and 2010 surveys. Case Mix prevalence is normalized rate of inpatient encounters of patients over the age of 18 averaged across calendar years 2009, 2011, and 2012 that had a diagnosis code beginning with any of the following digits: 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, or 319. APCD prevalence is the proportion of unique patients over the age of 18 in the year 2012 for which there is a claim with a diagnosis code beginning with any of the following digits: 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, or 319.

Costs

The per capita growth in total health care expenditures from 2012 to 2013 was 2.3%, which is below the Commonwealth's 2013 health care cost growth benchmark of 3.6% (Center for Health Information and

Analysis: <http://www.mass.gov/chia/docs/r/pubs/14/chia-annual-report-2014.pdf>). However, the spending growth in Massachusetts was consistent with growth trends nationwide. Even if previously implemented statewide reforms have begun to generate a trend of cost growth reduction, the Prevention and Wellness Trust Fund aims to generate further reductions to health care cost growth in the Commonwealth. DPH does not currently have health care expenditure estimates for each funded partnership.

Data Summary

To ascertain chronic disease burden in the state, we calculated prevalence from self-report data (BRFSS), insurance claims (APCD), and hospital data (Case Mix). Combining these data sources provides information on health risk and clinical outcomes across multiple settings (i.e. primary care as opposed to hospital visits). Multiple data sources indicate that funded partnerships have a higher disease burden, greater proportions of racial and ethnic minorities, and more people living below the Federal Poverty Line than the state as a whole (Figure 1, Tables 1-11). Thus the Prevention and Wellness Trust Fund has the opportunity to reach those at high risk and traditionally underserved by health care. In addition to reducing chronic disease burden, reaching these populations will improve health equity and reduce health care costs, maximizing return on investment. Analyses of future data from the above surveillance data sources, as compared to these baseline prevalence, will enable DPH to measure the effect of PWTF interventions at the community level.